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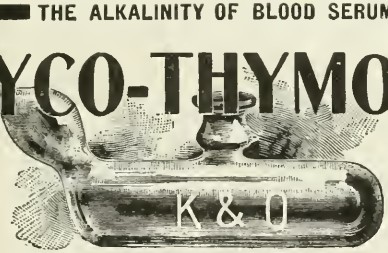

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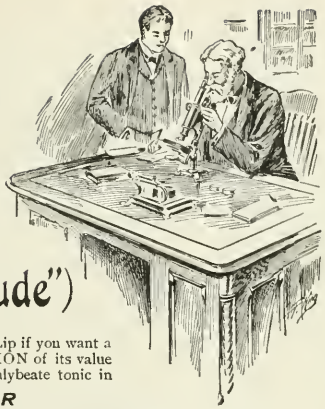

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DISEASES.

VOL. XX. OCTOBER, 1902. NO. 10.

Original Communications.

PRESIDENTIAL ADDRESS: THE AMERICAN DERMATOLOGICAL ASSOCIATION, AND ITS WORK DURING ITS FIRST QUARTER OF A CENTURY.*

BY GEORGE THOMAS JACKSON, M.D.,
New York.

GENTLEMEN: It gives me peculiar pleasure to preside over this meeting of our Association, because it was in this city thirteen years ago that I first attended a meeting of the Association.

But, alas, my pleasure is mixed with pain, a pain that most of you must share with me when you recall the circumstance that in 1889, when we met here before, the incumbent of the Presidential chair was our loved and lost friend, Dr. J. E. Graham. He was one of the best of men; warm of heart; clear of head; genial, loving, and to be loved. Little did I then dream that so soon he would die; he was so ruddy of countenance, apparently the picture of perfect health.

Dr. Graham was born in Brampton, Ontario, Canada, in May, 1847. His preparatory education was gained in the Weston Grammar School and the Upper Canada College. He graduated from the Toronto School of Medicine in 1869 at the head of his class, receiving both the University and the Starr gold medals. From Toronto he went to Brooklyn, N. Y., and became one of the resident physicians on the staff

* Delivered at the meeting of the American Dermatological Association, Sept. 18, 1902.

of the Brooklyn City Hospital. He subsequently studied medicine in Vienna and London, taking the degree of L.R.C.P., London.

He returned to Toronto in 1872 and began the practice of his profession. In 1875 he was appointed physician to the Toronto General Hospital. At about that time he became connected with the Toronto School of Medicine as Demonstrator of Anatomy and Microscopy. Subsequently he held the position of Lecturer on Chemistry. In 1887 he was made Professor of Clinical Medicine and Medical Pathology, and Lecturer on Dermatology. In 1892 he became Professor of Medicine.

In 1884 symptoms of diabetes showed themselves. The disease so impaired his health that he devoted himself more and more to the work of a consultant. In 1893 he left Toronto for a time, took up his residence in London, and gained the degree of M.R.C.P., London.

This brief sketch of Dr. Graham's life shows that he was a hard student, devoted to his profession, and worthy of all the honors and emoluments that were heaped upon him.

In 1873 he married Mary J. Aikins. To them were born three daughters and one son.

In 1899, when he felt that he could not live long, he resigned from our Association because he did not believe in belonging to any organization in which he could not do his full share of work. In that year he went south for his health, and was taken with influenza while in Baltimore. Unfortunately this was followed by slight pulmonary tuberculosis, which, engrafted on a system already greatly weakened by diabetes, was rapidly fatal. He died in Muskoka, Canada, on July 6, 1899, in the fifty-third year of his age. He was survived by his widow and four children. His son is a member of our profession. May his career be as honorable as his father's!

I am glad that it has so chanced that I stand here in the place in which he once stood, if only that I might put on record in our Transactions this sketch of his life and this expression, all inadequate though it is, of the esteem in which we all held him.

It is a remarkable fact that in the first quarter of a century that this Association has existed only three active members have died, namely: Dr. H. C. Hand, of St. Paul; Dr. E. Wigglesworth, of Boston, and Dr. R. B. Morrison, of Baltimore.

Dr. Hand I never knew. He was one of the original members of the Association, and died so early in its history that there appears a resolution upon his death in the first number of our Transactions in 1877. I am told by one who knew him well that he was a man of sterling character and fine attainments.

Dr. Edward Wigglesworth was one of those who signed the call that wakened our Association into life in 1876. Had he done nothing else that would have been a cause for lasting gratitude on our part. But he did much more. He was vice president of the Association from 1879 to 1881, and president from 1885 to 1886. He contributed three papers to our Transactions, and took an active part in our discussions. He attended our meetings regularly, and his genial manner added much to their success on the social side. His death was the first sad break in our ranks, and there was not one of us who did not mourn for him.

Dr. Wigglesworth was born in Boston on December 30, 1840. After receiving his preliminary education in Chauncey Hall and Latin Schools he entered Harvard College, from which he was graduated in 1861. From there he passed to the Harvard Medical School, from which he graduated in 1865. Being possessed of ample means, he studied in Europe for five years after gaining his diploma, returning to this country in 1870. From then until he died he practiced his profession in Boston, devoting himself to dermatology. For many years he was one of the physicians for diseases of the skin to the Boston City Hospital. He was a member of a number of medical societies, among which were our own Association and the Boston Dermatological Club. He was also a corresponding member of the New York Dermatological Society.

He was married in 1882 to Sarah Willard Frothingham, who, with his two children, survives him.

He died on January 3, 1896, in Boston, of apoplexy following Bright's disease, in the fifty-sixth year of his age.

Dr. Robert Brown Morrison became a member of this Association in 1884. He was its vice president from 1886 to 1887, and its president from 1893 to 1894. He contributed six papers to our Transactions, and like Dr. Wigglesworth added greatly to the success of our meetings by taking part in the discussion of papers. His death in 1898 is so recent that nearly all of you knew him, and to know him was to like him, for he was a thoroughly likable man. He was the soul of hospitality, and when we think of our meeting in Baltimore we recall his indefatigable and successful efforts to make it enjoyable.

Dr. Morrison was born in Baltimore on March 13, 1851. His preliminary education was received in Phillip's Academy, Exeter, N. H., from which in 1869 he went to Harvard College. He did not graduate in Arts, but went from Cambridge to study in Göttingen before taking up the study of medicine. He received his degree in medicine from the medical department of the University of Maryland. After a few years

of practical experience he went to Europe in 1882 and studied dermatology in Prague, Vienna, Hamburg and Berlin.

He was the first one to hold the chair of Dermatology in the Baltimore Polyclinic. He resigned this to become Clinical Professor of Dermatology in the University of Maryland, a position that he filled with distinction until 1889, when he received the high honor of being appointed Clinical Professor of Dermatology in the Johns Hopkins University, which he held until his death.

In 1878 he married Miss E. H. Williams, who, with his two daughters, survives him.

He died in September, 1898, in the city of his birth, of Bright's disease, in the forty-eighth year of his age.

By his will he gave to the Johns Hopkins Hospital his valuable medical library.

Since last we met in this city Drs. Graham, Wigglesworth and Morrison have died. We who knew them can but miss them while we meet here to-day.

The American Dermatological Association was founded in 1876. Its birthplace was Philadelphia, and it was the child of six fathers, namely: Dr. L. D. Bulkley and George H. Fox of New York, Dr. L. A. Duhring of Philadelphia, Dr. E. Wigglesworth of Boston, Dr. I. E. Atkinson of Baltimore, and Dr. L. P. Yandell of Louisville. These gentlemen sent an invitation to some fifty physicians in the United States who were interested in the subject of dermatology and syphilis to join with them in forming a national association for the study of those subjects.

It has seemed to me that an historical sketch of the Association during the first quarter of a century of its life just completed would be interesting and valuable. By the time the next quarter of a century is passed many of us will be but memories. But the Association will not die, and I venture to hope that a future historian will arise who will bring our history down to 1926.

The original members of the Association were I. E. Atkinson of Baltimore, W. Brodie of Detroit, A. Brooks of Hot Springs, T. R. Brown of Baltimore, L. D. Bulkley of New York, S. C. Bussey of Washington, R. Campbell of New York, H. F. Damon of Boston, W. H. Draper of New York, L. A. Duhring of Philadelphia, G. H. Fox of New York, H. C. Hand of St. Paul, W. A. Hardaway of St. Louis, C. Heitzmann of New York, J. N. Hyde of Chicago, B. J. Jeffries of Boston, E. L. Keyes of New York, F. F. Maury of Philadelphia, J. A. Octerlony of Louisville, H. G. Piffard of New York, A. R. Robinson of New York, C. J. Smith of Chicago, R. W. Taylor of New York, A.

Van Harlingen of Philadelphia, R. F. Weir of New York, F. D. Weisse of New York, J. C. White of Boston, E. Wigglesworth of Boston, and L. P. Yandell of Louisville.

It is evident that even at its beginning our Association was a representative one, its members coming from all parts of the United States. From a study of our records it is impossible to discover how many of the original members qualified. Five have resigned, five have been dropped for non-attendance, two have died, seven are unaccounted for, and ten are still active members.

The Association organized in 1876 by electing J. C. White, president; L. A. Duhring, vice president; L. D. Bulkley, secretary; and J. N. Hyde, treasurer.

The first annual meeting was held at Niagara Falls on September 4, 5, and 6, 1877. Every year since then the Association has met. There were present at the first meeting Drs. Atkinson, Brodie, Bulkley, Campbell, Duhring, Fox, Hardaway, Heitzmann, Hyde, Taylor, Van Harlingen, White, Wigglesworth, and Yandell. All of them except Dr. Brodie read papers.

A number of prominent European dermatologists were asked to take part in the proceedings of the first meeting, and many of them sent letters of congratulation upon the founding of the Association. Dr. Duckworth of London, sent a paper on the treatment of severe bed sores.

During the first twenty-five years of our existence we have been presided over by nineteen presidents, namely: James C. White from 1876 to 1878, and from 1896 to 1897; Louis A. Duhring from 1878 to 1880; James N. Hyde from 1880 to 1882 and from 1897 to 1898; Robert W. Taylor from 1882 to 1884; William A. Hardaway from 1884 to 1885; Edward Wigglesworth from 1885 to 1886; Henry G. Piffard from 1886 to 1887; Isaac E. Atkinson from 1887 to 1888; James E. Graham from 1888 to 1889; Prince A. Morrow from 1889 to 1890; Francis B. Greenough from 1890 to 1891; Edward B. Bronson from 1891 to 1892; George H. Fox from 1892 to 1893; Robert B. Morrison from 1893 to 1894; Samuel Sherwell from 1894 to 1895; Andrew R. Robinson from 1895 to 1896; John A. Fordyce from 1898 to 1899; Henry W. Stelwagon from 1899 to 1900; Francis J. Shepherd from 1900 to 1901. It will be observed that Drs. White and Hyde have served three terms as president, and Drs. Duhring and Taylor two terms each.

From 1876 to 1887 we elected two vice presidents every year; since then only one each year. Twenty-five of our members have served as vice presidents, namely: Louis A. Duhring from 1876 to 1877 and from

1896 to 1897; Robert W. Taylor from 1876 to 1877; Carl Heitzmann from 1877 to 1878 and from 1880 to 1881; Lucius D. Bulkley from 1877 to 1878; James N. Hyde from 1878 to 1879; Samuel Sherwell from 1878 to 1879 and from 1888 to 1889; Edward Wigglesworth from 1879 to 1880 and from 1880 to 1881; William A. Hardaway from 1879 to 1880 and from 1881 to 1882; George H. Fox from 1881 to 1882; Isaac E. Atkinson from 1882 to 1883 and from 1885 to 1886; Andrew R. Robinson from 1882 to 1883 and from 1885 to 1886; James E. Graham from 1883 to 1884 and from 1884 to 1885; Arthur Van Harlingen from 1883 to 1884 and from 1884 to 1885; Francis B. Grenough from 1885 to 1886; Robert B. Morrison from 1886 to 1887; Prince A. Morrow from 1887 to 1888; George H Tilden from 1889 to 1890; Le Grand N. Denslow from 1890 to 1891; Francis J. Shepherd from 1891 to 1892 and from 1895 to 1896; Henry W. Stelwagon from 1892 to 1893; George T. Jackson from 1893 to 1894 and from 1899 to 1900; John A. Fordyce from 1894 to 1895; Edward B. Bronson from 1897 to 1898; John T. Bowen from 1898 to 1899; Douglas W. Montgomery from 1900 to 1901. It will be observed that Drs. Atkinson, Duhring, Graham, Hardaway, Heitzmann, Jackson, Robinson, Shepherd, Sherwell, Van Harlingen, and Wigglesworth have served two terms each.

From 1876 to 1887 it was the custom to elect each year a secretary and a treasurer. After 1887 the two offices were held by one officer, who is known as the secretary and treasurer. During the twenty-five years there have been only nine secretaries, five of whom have discharged the duties of the double office.

Lucius D. Bulkley was secretary from 1876 to 1877, one year.

Robert W. Taylor was secretary from 1877 to 1879, two years.

Arthur Van Harlingen was secretary from 1879 to 1883, four years.

W. T. Alexander was secretary from 1883 to 1885, two years.

George H. Tilden was secretary from 1885 to 1889, four years. During the last two years he was also treasurer.

George T. Jackson was secretary and treasurer from 1889 to 1893 and from 1898 to 1899, five years.

Charles W. Allen was secretary and treasurer from 1893 to 1896, three years.

John T. Bowen was secretary and treasurer from 1896 to 1898, two years.

Frank H. Montgomery was secretary and treasurer from 1899 to 1901, two years, and is still the incumbent of the office.

The office of treasurer, when that office existed by itself, was held by five of our members, namely: James N. Hyde from 1876 to 1877,

one year; Isaac E. Atkinson from 1877 to 1882, five years; George H. Rohé from 1882 to 1886, four years; Le Grand N. Denslow from 1886 to 1887, one year; H. W. Stelwagon.

Up to 1891 the council consisted of the retiring president and the other officers of the society. In 1891 it was determined to elect each year a member-at-large to the council. The following ten members have served in that capacity: George H. Fox, 1891 and 1892; James C. White 1892 and 1893; John A. Fordyce, 1893 and 1894; P. A. Morrow, 1894 and 1895; John T. Bowen, 1895 and 1896; Edward B. Bronson, 1896 and 1897; George T. Jackson, 1897 and 1898; Andrew R. Robinson, 1898 and 1899; Thomas C. Gilchrist, 1899 and 1900; James C. Johnston, 1900 and 1901.

During the first twenty-five years of our existence we have had eighty members on our rolls. The names of the original members have been given already. I now give the names of those elected since 1876, with the years in which they were elected:

In 1877, W. H. Geddings of Aiken, S. H. Durkee of Boston, F. P. Foster of New York, S. Sherwell of Brooklyn.

In 1878, F. B. Bronson of New York, F. B. Greenough of Boston, and G. Rohé of Baltimore.

In 1879, J. E. Graham of Toronto.

In 1882, P. A. Morrow of New York, H. W. Stelwagon of Philadelphia, and W. T. Alexander of New York.

In 1884, G. H. Tilden of Boston, R. B. Morrison of Baltimore, F. C. Curtis of Albany, and L. N. Denslow of St. Paul.

In 1888, J. S. Howe of Boston, W. T. Corlett of Cleveland, G. T. Jackson of New York, H. G. Klotz of New York, F. J. Shepherd of Montreal, Canada, and J. Zeisler of Chicago.

In 1889, J. T. Bowen of Boston, and C. W. Allen of New York.

In 1890, C. W. Cutler of New York, J. A Fordyce of New York, M. B. Hartzell of Philadelphia, and J. Grindon of St. Louis.

In 1891, G. T. Elliot and L. Heitzmann of New York.

In 1892, A. Post of Boston.

In 1893, J. A. Cantrell of Philadelphia.

In 1894, S. Lustgarten of New York.

In 1895, I. Dyer of New Orleans, D. W. Montgomery of San Francisco, and J. McF. Winfield of New York.

In 1896, T. C. Gilchrist of Baltimore, and S. Pollitzer of New York.

In 1897, F. H. Montgomery of Chicago, M. B. Hutchins of Atlanta, and J. C. Johnston of New York.

In 1899, R. B. Carmichael of Washington, A. Ravogli of Cincinnati, H. H. Whitehouse of New York, and W. A. Pusey of Chicago.

In 1900, O. H. Holder of New York, G. W. Wende of Buffalo, and C. J. White of Boston.

In 1901, F. J. Leviseur and H. Goldenberg of New York, L. C. Pardee of Chicago, and G. H. Harding of Boston.

It will be noticed that new members have been added to our roll every year excepting in 1880, 1881, 1883, 1885, 1886, 1887, and 1898. The banner year was in 1888, when six new members were elected. It happens that of these four are now on the council, one of them being the president of last year, one the present incumbent of that office, one our vice president, and one the member-at-large of the council.

Of those elected since 1876, the names of thirteen no longer appear on our list of members, most of them having resigned.

Besides these active members we have elected from time to time the following honorary members: Prof. T. de Amicis of Naples, Dr. T. McC. Anderson of Glasgow, Dr. E. Besnier of Paris, Dr. H. R. Crocker of London, Dr. A. Hardy of Paris, Prof. F. Hebra of Vienna, Sir J. Hutchinson of London, Prof. M. Kaposi of Vienna, Prof. Leloir of Lillie, Prof. A. Neiser of Breslau, Prof. I. Neumann of Vienna, Prof. F. J. Pick of Prague, Prof. E. Vidal of Paris, and E. Wilson of London.

By looking over the subjoined list of our places of meeting, we find that we have been migratory. We have met in eleven states and in Canada. But wherever we have met we have found that our time was pleasantly and profitably passed. Up to 1807 our whole time was given to the reading and discussion of papers. It was then considered that it would be more to our profit if we devoted one session to the examination of patients and the discussion of their diseases. This has necessitated our meeting in the large cities. As we are a part of the Congress of American Physicians and Surgeons we have met every third year in Washington since 1888.

Our places of meeting have been as follows: Niagara Falls, N. Y., in 1877; Saratoga Springs, N. Y., in 1878; New York City in 1879; Newport, R. I., in 1880, 1881 and 1882; Lake George, N. Y., in 1883; West Point, N. Y., in 1884; Greenwich, Conn., in 1885 and 1886; Baltimore in 1887; Washington, D. C., in 1888, 1891, 1894, 1897 and 1900; Boston, Mass., in 1889; Richfield Springs, N. Y., in 1890; New London, Conn., in 1892; Milwaukee, Wis., in 1893; Montreal, Canada, in 1895; Hot Springs, Va., in 1896; Princeton, N. J., in 1898; Philadelphia., Penn., in 1899; and Chicago, Ill., in 1901.

Since the founding of the Association a volume of Transactions has been published every year. Up to 1803 these consisted merely in a brief summary of the papers and a report of the discussion of them.

In 1893 the first complete volume of Transactions was published giving papers in full and the discussions, together with illustrations of the papers. This was a distinct advance. In my opinion, we should never go back to the previous style. With our large and growing membership and the dignity our age gives us, nothing short of the complete report of our meetings is worthy of us.

Three hundred and seventy-six papers have been read before our Association. The least number in any one year was five, in 1882, and the largest number was twenty-six, in 1891. In 1884 and 1893 only eight were read, and only three times has the number exceeded twenty. The average number is fifteen. These 376 papers have been contributed by fifty-three of our members. Dr. Hyde has read the greatest number of papers, twenty-one. He is followed closely by Dr. Taylor with twenty, Dr. Duhring with eighteen and Dr. Stelwagon with seventeen.

The list of names of those contributing papers is here given, followed by a numeral indicating the number of papers read. Alexander (1), Allen (10), Atkinson (9), Bowen (7), Bronson (11), Brooks (1), Bulkley (10), Campbell (1), Cantrell (3), Corlett (9), Cutler (1), Denslow (3), Duhring (18), Dyer (2), Elliot (5), Fordyce (13), Foster (1), Fox (13), Gilchrist (6), Graham (8), Greenough (6), Grindon (4), Hardaway (12), Hartzell (8), Heitzmann (12), Holder (1), Hyde (21), Jackson (7), Johnston (4), Klotz (6), Montgomery, D. W., (3), Montgomery, F. H., (4), Morrison (6), Morrow (12), Piffard (6), Pollitzer (5), Pusey (1), Ravogli (1), Robinson (7), Rohé (2), Shepherd (9), Sherwell (14), Smith (1), Stelwagon (17), Taylor (20), Tilden (3), Van Harlingen (7), Wende (2), White, J. C. (15), Wigglesworth (3), Winfield (2), Yandell (1), and Zeisler (8.)

It is noticeable that as members are elected one year they almost invariably contribute a paper the next year.

Besides the 376 papers by the members of the Association, we have listened to six papers by invited guests. Dr. Duckworth of London, sent one on Bed Sores in 1877; Dr. DeSilva Lima of Bahia, sent one on Ainhum, in 1880; Dr. H. O. Schmidt in 1881 read one on the Pathology of Leprosy; Dr. P. G. Unna of Hamburg was with us in 1887, and read a paper on The Treatment of Leprosy, Dr. C. C. Ransom of New York, in 1890 gave an account of the action of the waters of Richfield Springs, and in 1893 Dr. H. R. Crocker of London read a paper on Lupus Erythematosus.

The subjects chosen for the papers have covered nearly the whole field of dermatology. A study of the subjoined list of subjects shows

that only three papers on eczema have been read, only one on trichophytosis, and none on dermatitis seborrhoicum.

In 1891 it was determined that a subject for general discussion should be chosen by the council each year. This was another distinct step in advance and has proved most successful. Since 1897 it has been the custom to select one or more of the members to present the chosen subject in well-studied papers, and this has been another step in advance. The subjects for general discussion have been the following: Alopecia areata (1892), Pityriasis rosea and Pemphigus (1893), Electrolysis (1895), Diet and Alcohol in Eczema and Psoriasis (1896), Syphilis (1897), Lupus Erythematosus (1898), The Rôle of Pus Organisms in Diseases of the Skin (1899), Malignant Diseases of the Skin (1900), and Diseases of the Nails (1901).

A list of the subjects presented for our consideration are here given. The numeral after the subject indicates the number of papers upon the subject:

Anatomy of the skin (3); Etiology, general considerations (3), cold (1), sleep (1), imperfect or deficient urinary secretion (1); Therapeutics (35) being upon acid, carbolic and salicylic, anthrarobin, aristol, calx sulphurata, chloral, cosmetics, diet, electrolysis, epilation, goose grease, ichthyol, iodine, iodoform, intrafollicular applications, lanolin, linseed oil, mineral waters, naphthol, oleates, petroleum, pilocarpin, resorcin, Roentgen rays, rubber plasters, salt, thilanin, and thyroid feeding; Classification (2); Dermatological hints (1); Teaching of dermatology (1); Scale of measurements (1); Acne (5); Acne varioliformis (1); Adeno-carcinoma (1); Ainhum (2); Alopecia (4); Alopecia areata (3); Angiokeratoma (2); Angioma pigmentosum et atrophicum (2); Angioma serpiginosum (1); Aspergillus nigrescens (1); Carbuncle (1); Carcinoma cutis (1); Chondroma of lip (1); Dermatitis (1), blastomycetica (6), exfoliativa (2), gangrenosum (3), hemostatica (1), herpetiformis (8), malignant papillary (2), medicamentosa (1), palmaris et plantaris (1), papillaris capilitii (2), protozoic (1), traumatica (1), vegetans (1), venenata (3); Dermatoses, germ (1), glycosuric (1), immigrant (1), trophic (1); Dysidrosis (1); Eczema (3); Eczema marginatum (1); Elephantiasis (2); Endothelioma (1); Epidermolysis bullosa (1); Epithelioma (3); Eruptions, feigned (1); Erysipelas (3); Erythema elevatum diutinum (1), induratum (1), multiforme (1), nuchae (1); Erythrodermie pityriasique en plaques disseminées (1); Exfoliation of lips (1); Favus (3); Folliculitis, agminated (1); Fordyce's disease of lips (1); Fragilitas crinium (2); Gangrenopsis (1); Granuloma (1); Hand and foot disease (1); Herpes gestationis (1), progenitalis (1), zoster (2); Hydroa estivale (1), vac-

ciniforme (1); Hydroadenitis (1); Hypertrichosis (4); Ichthyosis congenita (2); Impetigo contagiosa (2), herpetiformis (4), simplex (1); Keratosis follicularis (1); Kraurosis vulvæ (1); Lepra (12); Leucemia cutis (1); Leucopathia unguium (1); Lichen planus (5), ruber (4), scrofulosorum (2), tropicus (1); Lupus erythematosus (6), vulgaris (4); Lymphangioma circumscriptum (3), tuberosum multiplex (1); Malignant disease of the skin (5); Miliaria (1); Molluscum contagiosum (57), verrucosum (1); Mycetoma (1); Mycosis fungoides (7); Myoma multiplex (1); Myxangioma (1); Nevus (7), linare (1); Nails, diseases of (3); Negro, skin diseases of (1); Neuroses of the skin (3); Papilloma cutis (3); Parasitic diseases (2); Pediculosis (1); Pemphigus foliaceus (1), vegetans (1); Pityriasis rosea (1); Plica (1); Pompholyx (1); Porokeratosis (1); Prurigo (5); Pruritis (5); Psoriasis (7); Psorospermosis (1); Purpura (3); Rare diseases of the skin (11); Raynaud's disease (1); Rhinoscleroma (1); Rosacea (2); Rötheln (1); Sarcoma (5); Scabies (2); Scarlatiniaform eruption (1); Scleroderma (5); Scrofuloderma (2); Seborrhea (1); stigmata, bleeding (1); Sudamina (1); Sycosis capitis (1); Syphilis (29); Trichophytosis (1); Tuberculosis cutis (5); Tumors, multiple of skin (2), of scalp (1); Tylosis (1); Ulcers, buccal (1), multiple cachectic (1); Ulerythema sycosiforme (1); Urticaria pigmentosa (3); Variola (1); Vitiligo (1); Xanthoma (4); and Xeroderma (2).

This long list of papers by no means represents the literary activity of the members of this Association. Besides the hundreds of papers read by our members before other medical societies and published in many medical journals both in this country and in foreign lands, and articles contributed to various systems of medicine, there have appeared fifty-eight books written by twenty of our members. By their efforts the status of American Dermatology in foreign lands has been advanced to a high plane. American text-books on Dermatology are now studied by English-speaking students in all parts of the world. Had it not been for the impetus given by this Association to the study of dermatology in this country it is fair to assume that this would have not been the case.

The books on Dermatology and Syphilis written by our members are as follows:

Bulkley, L. D. 1. Eczema and its management, N. Y., 1881; 2d Ed., 1884; 3d Ed., 1900. 2. Manual of skin diseases, N. Y., 1882, 4th Ed., 1898. 3. A treatise on acne, N. Y., 1885. Acne and alopecia, Detroit, 1892. Syphilis in the innocent, N. Y., 1895.

Corlett, W. T. A treatise on the acute infectious exanthemata. Phila., 1901.

Cutler, C. W. 1. Differential diagnosis of the disease of the skin, N. Y., 1887. 2. Lectures on dermatology, N. Y., 1894.

Duhring, L. A. 1. A practical treatise on disease of the skin, Phila., 1877; 2d. Ed., 1881; 3d Ed., 1882. 2. Atlas of skin diseases, Phila., 1877 to 1883. 3. Epitome of skin diseases, Phila., 1886. 4. Cutaneous medicine, Phila., 1892 et seq.

Fox, G. H. 1. (with Piffard) Venereal and cutaneous memoranda, N. Y., 1877, 2d Ed., 1880. 2. Photographic illustrations of skin diseases, N. Y., 1880, 2d. Ed., 1885. 3. Photographic illustrations of cutaneous syphilis, N. Y., 1881. 4. The use of electricity in the removal of superfluous hair and other facial blemishes, Detroit, 1886. 5. Photographic atlas of skin diseases, N. Y., 1897. 6. The skin disease of children, N. Y., 1897. 7. Photographic atlas of skin diseases, Physicians' edition, Phila., 1901.

Hardaway, W. A. 1. Essentials of vaccination, Chicago, 1882. 2. Manual of skin diseases, St. Louis, 1890, 2d. Ed., Phila., 1898. 3. (with Bangs) American text-book of genito-urinary diseases, syphilis, and diseases of the skin, Phila., 1898.

Hyde, J. N. 1. A practical treatise on skin diseases, Phila., 1883; 2d Ed., 1888; 3d Ed., 1893; 4th Ed. (with Montgomery) 1897; 5th Ed., 1900; 6th Ed., 1901. 2. On the affections of the skin induced by temperature variations, etc., Chicago, 1886. 3. (with Montgomery) Manual of skin and venereal diseases, Phila., 1895; 2d Ed., 1900. 4. Smallpox in Illinois, Chicago, 1900.

Jackson, G. T. 1. Diseases of the hair and scalp, N. Y., 1887; 2d Ed., 1894. 2. The ready reference handbook of skin diseases, Phila., 1892; 2d Ed., 1896; 3d Ed., 1899; 4th Ed., 1901.

Johnston, J. C. Atlas of skin and venereal diseases, N. Y., 1901.

Keyes, E. L. 1. (with Van Buren) Genito-urinary diseases and syphilis, N. Y., 1874. 2. The tonic treatment of syphilis, N. Y., 1877. 3. Venereal diseases, N. Y., 1880; 2d Ed. (with Chetwood) N. Y., 1899. 4. Genito-urinary diseases and syphilis, N. Y., 1888. 5. Some fallacies concerning syphilis, N. Y., 1889.

Morrow, P. A. 1. Syphilis and marriage (from the French), N. Y., 1881. 2. Drug eruptions, N. Y., 1887. 3. Atlas of skin and venereal diseases, N. Y., 1889. 4. A system of genito-urinary diseases, syphilis, and dermatology, N. Y., 1892 to 1894.

Piffard, H. G. 1. 2. (with Fox) Venereal and cutaneous memoranda, N. Y., 1877; 2d Ed., 1880. 3. 4. Materia medica and therapeutics of the skin, N. Y., 1881. 5. Cutaneous memoranda, N. Y., 1885.

An elementary treatise upon diseases of the skin, N. Y., 1876. Bibliotheca dermatologica, N. Y., 1879. 6. The modern treatment of eczema, Detroit, 1886. 7. A practical treatise on diseases of the skin, N. Y., 1891.

Ravogli, A. Hygiene of the skin, Cincin., 1888.

Robinson, A. R. A manual of dermatology, N. Y., 1884.

Rohé, G. H. 1. Practical notes on the treatment of skin diseases, Balt., 1885; 2d Ed., 1886. 2. (with Lord) A practical manual of skin diseases, Phila., 1892.

Stelwagon, H. W. 1. Essentials of diseases of the skin, Phila., 1890; 2d Ed., 1894; 3d Ed., 1899. 2. Mracek's handbook of diseases of the skin, Phila., 1899.

Taylor, R. W. 1. Syphilitic diseases of the osseous system in infants and young children, N. Y., 1875. 2. (with Bumstead) The pathology and treatment of venereal diseases, N. Y., 4th Ed., 1879; 5th Ed., 1883. 3. Clinical atlas of venereal and skin diseases, Phila., 1888. 4. The pathology and treatment of venereal diseases, Phila., 1895. 5. A practical treatise on sexual disorders in the male and female, Phila., 1897, 2d Ed., 1900. 6. A practical treatise on genito-urinary and venereal diseases and syphilis, Phila., 1900.

Van Harlingen, A. A handbook of the diagnosis and treatment of skin diseases, Phila., 1884; 2d Ed., 1889; 3d Ed., 1895.

White, J. C. Dermatitis venenata, Boston, 1887.

An account of the literary activity of the members of this Association would be incomplete that did not mention the Journal devoted to our specialty that under various names has been maintained through the whole life of our Association by some of its members. The work has been a labor of love, for the journal has been run at considerable loss at times. It has always been a periodical of the first class, and a credit to its editors.

Dr. L. D. Bulkley issued the first number of *The Archives of Dermatology* in October, 1874, and continued its publication until October, 1882. Drs. H. G. Piffard and P. A. Morrow issued the first number of *The Journal of Cutaneous and Venereal Diseases* in October, 1882, and continued in the joint editorship until 1886, when Dr. Piffard retired.

Dr. P. A. Morrow continued the Journal as its sole editor. In 1887 the title was changed to that of *The Journal of Cutaneous and Genito-Urinary Diseases.* In 1889 Dr. J. A. Fordyce was associated in the editorship, and in 1892 he assumed entire charge, Dr. Morrow retiring. In 1896 Dr. J. C. Johnston was associated with Dr. Fordyce in the management of the journal. In 1897 Dr. Fordyce retired and since

then the journal has been conducted by Drs. Johnston and Swinburne with the coöperation of six of our members.

Since the foundation of our Association we have published statistical tables showing the frequency of skin diseases in this country. The first chairman of the committee on statistics was Dr. J. C. White. For the past seventeen years Dr. J. N. Hyde has been the chairman. It is to be regretted that these statistics are not as complete as they should be. This incompleteness is not due to any lack of effort on the part of the committees, but to an apparent lack of interest on the part of the members. Even taking into account the incompleteness of the returns the tables are the most complete of anything of the kind in the world, and are of value as shown by the frequency with which they are quoted. The first report of the committee was made in 1877, and the number of cases reported was 17,000. There were reported in 1891 22,455 cases, and the combined returns for the twenty-five years cover 386,426 cases.

Thus ends the history of our past. The future of the Association is assured. We have always preserved a high standard of requirements for the admission of new members, and this should be kept high. No one should be admitted into our fellowship unless he has made himself known to most of us by the excellence of his work. A purely local reputation should not be considered sufficient for admission into our body.

The record of the past is one of which we may well be proud. With the passing years we have grown stronger and stronger and we come down to the present with a membership of forty-eight from all parts of this country and from Canada. We are a harmonious body working for the honor of our Association, and the work we do is of the highest grade.

TWO CASES OF MALIGNANT VASCULAR TUMOR (PERITHELIOMA) OF THE SKIN.

By Paul G. Woolley, B.S., M.D. (J. H. U.),
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And

E. Hamilton White, B.A., M.D. (McGill),
Resident Medical Officer, Montreal General Hospital,

MALIGNANT vascular tumors of the skin have been described by but few authors, and have been called with but few exceptions, so far as we can find, endotheliomata or angio-sarcomata, no distinction being drawn between the endo-vascular or peri-vascular types.

From a somewhat hasty review of the literature we might have come to the conclusion that the perithelial variety was very uncommon had it not appeared from illustrations of growths described as endotheliomata that these were really peri-vascular types of tumors arising about blood vessels. But even so, these tumors arising in the skin are not common, and that they occur in youth so commonly is interesting.

Fordyce (*Am. Journ. Med. Sc.*, 1900, cxx, 159) has described cases of endotheliomata of the skin. In one case the new growth occurred in the arm, at the site of a lupus ulcer. This patient was a woman, 46 years old. The growth had been superficially excised before a diagnosis had been made, and it had recurred. It was finally entirely removed. This histological examination proved it to be a blood vascular tumor. The second case, also of Fordyce, occurred in a woman 40 years old, and the third in a girl of 10 years. The tumors in both of these cases were on the scalp. In a fourth case, the growth appeared at the site of a wart on the abdomen of a boy 12 years old.

Winfield (Journal of Cutaneous and Genito-Urinary Diseases, 1900, xviii, 113) reported an angio-sarcoma of the chest wall of a boy 15 years old. The original tumor had been excised, and at the site of excision recurrences were noticed one month later. Eight months later the small and larger growths occupied an area measuring three

by four inches in diameter. The subsequent history is not published as far as we can find.

Wolters (*Arch. Derm.*, 1900, liii, 269) describes two cases of angiomata, one of which he calls hemangio-endothelioma tuberosum multiplex and one hemangio-sarcoma cutis. This later growth, he says, originated in the vascular adventitia and would therefore fall under the head of the peritheliomata. It is to such a group that our cases described below belong.

Case I.—An Italian boy, 10 years old, who came to the hospital with a small tumor on his great toe, over the phalangeal joint. He dated its growth from a blow received about two weeks before. It was about 1 cm. in diameter and was shaped like the top of a small mushroom. It was bright red in color, and had a smooth surface, only slightly tender, but bleeding readily when rubbed. The edges were free, the growth being set upon a short slender pedicle.

When the pedicle was divided, free bleeding took place from a small artery in it.

After the first dressing, the lad did not return to the clinic.

The tumor, as it was seen in the pathological laboratory, was a rounded, flattened piece of tissue, reddish-brown in color, with an irregular nodulated surface measuring about 1 cm. in diameter. It was fixed in Zenker's fluid, imbedded in paraffin and cut in serial sections. Sections were stained with hematoxylin and eosin, thionin, methylene blue, Mallory's stain, and Van Gieson's stain.

Grossly it was composed of very vascular tissue with thick bands of fibrous tissue arranged in a more or less radial manner, the radiation extending from the center toward the periphery. There was very little epithelium present on the surface of the tumor, a few small islands appearing in one or two places. The remainder of the surface was covered with a proliferated fibrous tissue containing a large number of polymorphonuclear leucocytes. This infiltration extended inward for not more than one millimeter.

The mass of the tumor was composed of well-formed blood vessels, the majority of which contained no blood cells. In all of these the endothelial lining was intact. Outside the endothelium and invading the peri-vascular supporting connective tissue were cells of both epithelioid and fibroblastic characters, forming the picture of either a pure perithelioma, or of a spindle-celled sarcoma, as the case might be. In the center of the tumor the sarcomatous type prevailed, nearer the periphery the peritheliomatous type.

The tumor is undoubtedly a perithelial hemangio-sarcoma. In some instances there is but a single layer of endothelial cells about the ves-

sels, in others the inter-vascular spaces are completely filled with these cells and the gradual spread of the involvement can be seen following along the inter-vascular connective tissue. Where the resistance to growth is greatest, *i.e.*, in the center of the growth, the spindle-celled type prevails; at the periphery the perithelial type is most prominent.

The nuclear figures are abundant, and irregular mitoses are frequent. There is no evidence of pigmentation.

Case II.—The patient was a child of 3½ years, and the tumor in this case appeared on the scalp. There was no history of trauma. The growth was in the form of a small pendulous tag arising over the posterior branch of the temporal artery. It was about 1½ cm. in length and of a pinkish color, and with some hair on its surface. The growth in this case was not as distinctly pedunculated as in the previous case.

It had been first noticed about a month before the child was brought to the clinic, and since its appearance its growth had been gradual. In this case the pedicle was ligatured before removal, and after division the base was cauterized.

The tumor has the same general appearance as the first, and was almost exactly similar in structure. It, too, had been irritated, and at one place was ulcerated. The epithelium in this case, too, extended down into the tumor in well-defined strands, and these were surrounded by a typical vascular sarcomatous tissue arising from the perithelium of the blood vessels, which formed an intricate mesh-work, and which, for the most part, contained blood.

This case, like the first described, is one of perithelial hemangiosarcoma.

FATTY DEGENERATION OF THE BLADDER AS A FACTOR IN THE PATHOLOGY OF GENITO-URINARY DISEASE IN MIDDLE AND ADVANCED LIFE.

BY G. FRANK LYDSTON, M.D.,
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Professor of Genito-Urinary Surgery and Syphilology, State University of Illinois; Surgeon to St. Mary's Hospital; Late Professor of Surgery, Chicago Clinical School.

WHILE the present operative treatment in obstructive diseases of the prostate is justly dominating the profession, the consideration of conditions which produce independently urinary retention or enter as a factor into the retention produced by prostatic obstruction would seem to be timely. Fatty degeneration of the prostate and bladder is a condition not generally recognized. That it is an important factor in genito-urinary pathology I am convinced from the observation of several distinct cases. These I will report:

Case I.—J. B., aged 40. General history unknown, excepting the fact that he had been a hard drinker all his life. The condition of the urinary apparatus previous to death unknown, save as indicated postmortem. Patient died of delirium tremens with acute retention. Conditions found on autopsy and subsequent careful examination of the genito-urinary tract were as follows:

Macroscopic Characteristics.—Meatus urinarius considerably contracted. This was in part congenital, but mainly the result of a cicatrix, evidently from old-time chancroid. The urethral mucous membrane was thickened in plaques, and there were two distinct annular strictures of moderate caliber, the result, evidently, of an old gonorrhea. The prostate was slightly enlarged. The mucous membrane of the prostatic urethra was hyperemic and thickened. The veru montanum was considerably enlarged, but rather pale and firm to the feel, from chronic inflammation and connective tissue hyperplasia. The mouths of the prostatic ducts were found with some difficulty, being considerably contracted; indeed, almost obliterated by chronic inflammation. The bladder was largely distended by apparently normal urine. The mucous membrane corresponding to the prostato-vesical junction was pale and thickened from chronic inflammation and hyperplasia. Above this was a collar-like area of hyperemic mucous membrane, showing chronic

inflammation of a more recent date than that at the prostato-vesical junction. This hyperemic area was of irregular form, from one-half an inch to one inch in width, and was arborescent throughout. The surface of the mucous membrane was granular, especially laterally. The mucous membrane of the bladder above this annular area looked fairly healthy, aside from distinct telangiectatic areas in which the arborescent appearance of the blood vessels was beautifully marked. The seminal vesicles were healthy. The prostate body proper and the wall of the bladder plainly showed fatty degeneration, having very much the appearance of yellow beef fat. By the naked eye, no muscular structure could be detected.

The kidneys were acutely congested, and showed distinct areas of interstitial nephritis.

Microscopic Characteristics.—The prostate and bladder wall were alone examined. These structures were found to be the seat of extensive fatty degeneration, the muscular fibers being few and far between and such as existed being infiltrated with fat. There was a moderate increase of interstitial connective tissue. The impression made upon me by this specimen was, first, that acute retention in such cases must necessarily be followed by permanent atony, and, second, that severe and prolonged retention in such cases should rationally be expected to result in vesical rupture.

Case II.—D. M., forty-five years of age. Died of acute alcoholism with retention. This patient had a history of bladder trouble. As to what this consisted of, the history did not show, and the physician who had charge of the patient prior to his sudden death was unable to give me any information. A complete autopsy was made in this case.

Microscopic Examination.—Both kidneys were enlarged and glandular, showing chronic interstitial changes. The heart was markedly hypertrophied, and the seat of extensive fatty changes, associated with atheromatous patches and mitral insufficiency. The liver was enlarged and fatty, with an excess of connective tissue. There was pronounced arterio-sclerosis of the renal arteries. The bladder was full of slightly turbid urine, extending midway to the umbilicus. The tissues surrounding it were distinctly edematous. The immediate cause of death was uremia, precipitated by a debauch.

The bladder in this case was one of the most interesting specimens I have ever examined. Both the prostate and bladder showed the same fatty changes as in the preceding case. There was a distinctly marked *bas fond*, which could not be explained by any obstructive condition at the vesical neck. The only explanation, apparently, was the fatty degeneration of the bladder wall and its gradual yielding to the pressure of

the urine. The microscope showed fatty changes which were fully as marked as in Case I.

Case III.—W. B., aged 47. In this case sudden death from chronic myocarditis succeeded an alcoholic debauch. Previous history absolutely unknown. Prostate and bladder only examined by me.

Macroscopic Appearance.—The prostate was of normal size. The urethra tunneled the prostate to the left of the median line, being barely covered in laterally, the bulk of the prostate being situated to the right of the urethra. The bladder was dilated and columnated. There was a large quantity of perivesical fat. Both prostate and bladder showed to the naked eye marked fatty changes. There was a slightly marked *bas fond*, with a distinct intraureteral bar. There was no prostatic obstruction.

The bladder was moderately distended with normal-looking urine. One-half inch posterior to the opening of the right ureter was a sacculus as large as a good-sized hazelnut. About an inch external to the left ureteral opening there was a sacculus as large as a good-sized hen's egg. The vesical opening of this latter sacculus measured three-eighths of an inch in diameter. Both sacculi were empty. The mucous membrane was trabeculated, and showed evidences of recent more or less acute inflammation, with engrafted chronic inflammatory change. The mucosa was markedly arborescent, especially in the vicinity of the openings of the sacculi. The anterior and left lateral aspects of the mucosa were comparatively healthy. The prostatic urethra was normal.

Microscopic Characteristics.—Sections showed extensive fatty degeneration of both bladder and prostate. The sacculation of this bladder, unassociated with a distinct obstruction at the vesical outlet, is worthy of note. There is little question but that this patient had suffered from vesical atony for a prolonged period. The functional capacity of the bladder muscle could be gauged with a fair degree of accuracy from the marked condition of fatty degeneration shown, not only by the microscope, but by the naked eye. The openings or rims of the sacculi were well rounded and thickened, which would seemingly indicate their long-standing, and probably their congenital character. I say that they were probably congenital, because there was no obstruction at the vesical neck, which, even in the presence of the extensive fatty change, could have produced sacculation of the bladder.

Another interesting point is the fact that such marked pressure as was necessary to form these sacculi would probably have produced a complete rupture of so degenerated a vesical wall long before sacculi of any size could have formed.

The most important point in connection with the foregoing cases

is their relation to the occurrence of sudden retention in old or even middle-aged men, in whom no perceptible organic prostatic obstruction can be found. Alcoholism probably constituted an important element in the etiology of these cases, and the acute retention which so often follows an alcoholic debauch may perhaps be explicable in many instances by fatty degeneration of the bladder, whether obstruction at the vesical outlet exists or not. Certainly, such fatty degeneration must be a very important factor in the atony following prolonged retention of urine, which often occurs in patients at or above middle life.

Another very important point is this: This fatty degeneration of the bladder muscle is by no means limited to patients who are free from prostatic obstruction. It may be associated with prostatic disease. It constitutes one of the causes of the failure of radical operations, of whatever kind.

As a condition predisposing to vesical rupture in case of traumatism of a full bladder, such fatty degeneration as I have described is certainly worthy of consideration. Where this fatty degeneration exists a very moderate degree of temporary spasmodic or congestive obstruction at the vesical neck is sufficient to bring about acute retention. In such cases as those described, the balance between the *vis a fronte, i.e.,* the equilibrium of the resistance of the cut-off and sphincter muscles, and the *vis a tergo, i.e.,* the contractile power of the degenerated bladder wall, is very delicate, and a very slight disturbance is sufficient to overcome the *vis a tergo* altogether, and produce retention. This is especially the case after the floor of the bladder has been lowered, with the resulting formation of a *bas fond*, in cases of obstruction at the vesical neck.

It is wise, in the face of such degenerative conditions as I have described, not to claim too much for any radical operation upon the prostate, in cases of obstructive disease. From the enthusiasm with which some surgeons are booming various operations upon the prostate, one would infer that the morbid anatomy of vesical and prostatic disease had been revolutionized for the express benefit of operators by one or another radical method. The possible benefits to be derived from radical operations upon the prostate and bladder should always be discounted in the face of the various degenerative changes, and particularly fatty degeneration, which may exist either as a primary or secondary condition in chronic genito-urinary disease.

DERMATOLOGICAL CASES (ZOSTER GLOSSITIS).

By MAX REICHMAN, M.D.,
Chicago.

1. Herpes zoster menstrualis sacro-lumbaris.

G. P., French-Canadian, age 35 years, has been under my observation since February, 1900. Her father died from tuberculosis pulmonum, her mother at birth of the patient. At the age of 18, patient had an attack of typhoid fever; at 28, pneumonia. One year later she acquired syphilis through her husband. She was treated for two years and had no recurrence until 1900, when an eruption appeared on the mucosa of the mouth. I prescribed mercury inunctions and internal administrations of pot. iodid; she recovered and has not shown any symptoms since.

Menstruation, which set in at the age of 12 years, was always scanty. For the last ten years patient claims to have noticed regularly an eruption of vesicles in the left sacro-lumbar region at the time of each menstruation, which eruption was preceded for a period of two to three days by considerable burning and was accompanied by moderate itching. After eight to ten days all symptoms disappeared without any treatment.

This history I obtained from the patient in September, 1900, when she called my attention to a group of dried-up vesicles in the left sacro-lumbar region. The following month I was able to observe the eruption at the height of its development.

There was a group of limpid vesicles the size of a silver dollar upon the left sacro-lumbar region. The surrounding skin, however, showing no pathological changes. In November, the eruption appeared for the first time symmetrically, *i.e.*, on both sides, although the right one was less affected than the left.

Patient showed at that time extraordinary irritability, the touching alone of the diseased parts causing trembling of the body and chattering of the teeth, I prescribed for her acid-arsenicosum in pills (a) 0.001 three times daily in increasing doses. The eruption recurred on the following December and January, and then on one side only; since then there was no relapse.

I consider this case an extraordinary one, although cases of cutane-

ous eruptions of different types at the times of menstruation are not so rare.

Thus Bergh[1] in an extensive article, which includes numerous references from literature, reports a case of vesicular eruption on the female genitalia at the time of menstruation and compares it with the herpes progenitalis of the male.

Levin[2] also reports on the appearance of small vesicles on different parts of the body during menses, but such constant and regular appearance of a typical herpes zoster in the same region of the body as in my case, I have not found recorded.

2. *Glossitis superficialis chronica (Moeller).*

E. G., American, 18 years old, single, was first seen in May, 1900. Family history good, no similar affection in any member of the family. Patient is poorly developed, having the appearance of a girl of 14; suffers acutely from an affection of the tongue while partaking of hot or seasoned food for the last three years. For about six years she complained of obstinate constipation and very poor appetite. Menstruation set in at the age of 16, always regular, and the flow was extremely weak, accompanied by severe pains in the back. The patient is of gracile build, weighs 87 pounds, complexion very pale, visible mucous membranes very anemic. The sounds of the heart clear but weak; internal organs normal. In the submaxillary region of the right side is felt a hard indolent tumor which is said to have persisted since childhood.

The upper surface of the tongue shows a brown coating; the tip, margins and lower surface are covered with bright red papules of lentil size, the center of which is white without exception. Similar papules are noted on the mucous membrane of the cheeks and lips, and especially at the angles of the mouth.

I made the diagnosis of a mycotic infection, being unable, either from the history or from careful objective examination, to obtain any evidence of syphilis; but neither a microscopical examination for fungi nor antimycotic treatment, which was continued for a considerable length of time without improvement, seemed to confirm the correctness of my diagnosis. A histo-pathological examination of an excised fresh papule, for which I am indebted to Dr. Gustave Futterer, showed an enormous small cell infiltration with loss of epithelium. I had, in other

[1] R. Bergh.—Ueber Herpes menstrualis, *Monatsch. f. prakt. Dermat.*, Bd. 10. No. 1.

[2] E. Levin.—Ueber Herpes bei Frauen und seine Beziehungen zur Menstruation, *Deutsche Med. Wochenschr.*, 1900. Nos. 17 and 18.

words, a case of glossitis superficialis chronica, which was first described by Moeller and afterward by Michelson,[1] Joseph[2] and Preuss.[3]

According to the advice of Joseph, the affection was now treated with strong lactic acid applications without any effect; however, better results seemed to be obtained by a huckleberry decoction recommended by Preuss as an astringent mouth wash, although I do not hesitate to attribute the decided improvement manifested in the last few months to the systematic treatment of the patient's anemia, consisting in the prolonged use of arsenic and iron preparation as well as proper hygienic and dietetic measures.

Notes.

CORRECTION.—The editor of the *Russian Journal* desires us to make this correction. The work credited on p. 244 to "Prof. Zehner's Clinic" belongs properly to Prof. Selenew's Clinic. It is a praiseworthy custom to recognize in this way the institution whose facilities are used, and we are pleased to further it in any way.

THE SECOND INTERNATIONAL CONFERENCE OF PROPHYLAXIS OF SYPHILIS AND VENEREAL DISEASE has taken place in Brussels from the 1st to the 6th of September, 1902. The following program is arranged for the conference:

I. Public Prophylaxis.

Whereas, on the one hand, it is the duty of the public authorities to safeguard society against contagious diseases, which, by their frequency and by the faculty with which they are spread, constitute a public danger; and while on the other hand, quite apart from the sanitary point of view, it is their mission to protect minors abandoned by their parents;

A.—What measures of public prophylaxis, under the form of legal provisions, should be taken against venereal diseases, specially with reference to the following points:

RELATIVELY TO PROSTITUTION:

1. The prostitution of minors;
2. The action of public bodies whether in the interest of public morality and tranquillity, or from a sanitary point of view;
3. Procurers and bullies.

[1] Michelson.—Ueber einige seltenere Zungenkrankheiten, *Berliner Kl. Wochenschrift*, 1890, No. 46.

[2] M. Joseph.—Beitrag zur Glossopathologie, *Deutsche Med Wochenschr.*, 1891, No. 18.

[3] Preuss.—Zur Pathologie der Zunge, *Centralbl. f. Chirurgie*, 1893, No. 9.

NOT ASSOCIATED WITH PROSTITUTION:

1. The protection of minors of both sexes;
2. The organization of measures of relief for those suffering from venereal diseases; the duties of charitable institutions to those so suffering;
3. Suckling by wet nurses;—contagion by midwives and nurses;—arm to arm vaccination;—contagion in factories and workshops by means of instruments of labor;—registry offices, etc.
4. Is it necessary to apply the principles of civil and penal responsibility for the transmission of venereal diseases?

II. Individual Prophylaxis.

Taking into consideration that if the public authorities have to take prophylactic measures against venereal diseases, the duty of self-preservation is incumbent on every one; on the healthy, by the avoidance of all dangerous contact with an infected subject, and on the diseased by avoiding the posssibility of infecting others;

1. What are the best means of enlightening the youth and the general public on the social and individual dangers of syphilis and gonorrhea, as well as the methods of contagion of these two diseases, direct or indirect?
2. How can one best facilitate individual prophylaxis by means of charitable institutions (dispensaries, refuges, etc.) and the medical treatment of patients of both sexes suffering from syphilis or gonorrhea?

III. Statistics.

What should be the uniform basis on which the statistics of venereal diseases in all countries should be formulated?

IV. Personal Communications.

In conformity with the decision of the first Conference, personal communications may be introduced, with the consent of the Committee on subjects not dealt with in the Programme, and a special sitting will be devoted to their consideration.

An account of the Proceedings of the Conference will be given in the next issue.

Selections.

CUTANEOUS DISEASES.

The Clinical Aspect and Histology of Bazin's Erythema Induratum (Neisser's Clinic). WILHELM HARTTUNG and ARTHUR ALEXANDER (*Arch. f. Derm. and Syph.*, Vol. 60, 1902, p. 40).

The case of a man of thirty who came under hospital observation of the writers, presents the material for this study. The first examination of the patient's disease suggested the possibility of malignant endotheliona, but further study enabled the writers to arrive at the foregoing diagnosis, which they substantiated by thorough clinical microscopical and bacteriological examination. During the patient's sojourn in the hospital he received three injections of tuberculin, which was followed by an eruption of lichen-scrophulosorum-like lesions, but no local reaction took place on the sites of the patches and nodules of the disease. Neither did an improvement follow a vigorous antisyphilitic treatment. The local condition of the erythema did not get worse after the use of iodid of potash. No tubercle bacilli could be found in the sputa in the first sojourn of the patient in the hospital, but six months later when the patient was in a hospital suffering with pleuropneumonia, tubercle bacilli were found. The patient succumbed and the autopsy showed tuberculosis of the lungs, of the spinal cord and a tuberculous sinus of fourth vertebra. Animal inoculation performed immediately after the death of the patient gave negative results. The histological examination of excised tumor proved to the satisfaction of the writers the presence of many real tubercles (Neisser in the discussion expressed the opinion that the histological pictures of the sections of the tumors do not impress him as being tubercular. Ref.), which in their opinion entitled them to consider the tumors and other local lesions of tuberculous origin, in spite of the negative results obtained from animal inoculation, from the injection of tuberculin and in spite of the failure to demonstrate the presence of tubercle bacilli in the tissues of the lesions.

Plato's Experiments in the Preparation and Use of "Trichophytin."—Reported after his death by A. Neisser (*Arch. f. Der. and Syph.*, Vol. 60, 1902, p. 53.)

The late Dr. Plato, during his assistantship in Neisser's clinic, undertook to prepare a special preparation of trychophytin and investigate its action upon patients suffering with trichophytosis, following the line of investigation on tuberculin. Prof. Neisser gives the method of preparing the trichophytin and a résumé of the clinical results, obtained in his clinic by the late Plato from its injection. Trichophytin obtained from the culture of a parasite of a deep trichophytosis and injected into a patient suffering with deep trichophytosis will produce "a general reaction": the temperature will rise and symptoms of general intoxication will be noticed. At the same time a local reaction seems to take place manifesting itself objectively by a hyperemia and formation of pustules and subjectively by increased burning sensation of the affected portions. The cases where general and local reaction takes place a therapeutic effect is

undeniable. The trichophytin has only a specific reaction in cases which are due to the same parasite from which the trichophytin was obtained. Healthy persons as well as in persons suffering with other affections exhibit no reaction from trichophytin injections. It is to be noticed that there exists a difference between deep and superficial trichophytosis. Trichophytin obtained from deeply seated trichophytosis does not act in persons with a superficial disease. Trichophytin does not produce a reaction similar to that of tuberculin in tuberculous patients, neither does trichophytin act upon patients suffering with favus. "Favin" obtained in the same manner as trichophytin does not produce any reaction in patients suffering with favus.

1. **A Peculiar Inflammatory Disease of the Skin of the Nose in Young Individuals, Associated with Hyperhidrosis.**—HUGO HERMANN (Neisser's Clinic) (*Arch. f. Derm. u. Syph.*, Vol. 60, 1902, p. 77).

2. **About Granulosis Rubra Nasi** (Jadassohn). W. PICK (Prof. Pick's Clinic) (*Arch. f. Derm. u. Syph.*, Vol. 62, 1902, p. 105).

Nine more cases of this peculiar affliction are added to those first published by Jadassohn under the name "Granulosis rubra nasi." (See JOURNAL, 1902, p. 134.) The clinical aspect of the disease as described by the writer corresponds in every particular with the description of Jadassohn, the difference being in the sex of the patients; boys predominating in Hermann's cases.

Jadassohn describes the presence of enlarged ducts and coils of the sweat glands; the present writer did not notice any enlargement in his microscopical sections.

Pick (2) reports another case with histological examinations of an excised portion of the affected skin. He directs the attention to the marked and constant hyperidrosis of the affected portion, a symptom upon which the former writers did not lay enough stress, and he suggests the addition of "e hyperidrosi" or "cum hyperidrosi" to Jadassohn's original name, Granulosis rubra nasi. The hyperidrosis is absent upon the papules. His histological findings are in accord with those of Jadassohn. He does not suggest any therapy, as all remedies tried failed to improve permanently the condition.

Microscopical Investigations Regarding the Significance of the Zone of Reaction After Injections of Tuberculin. — By VIKTOR KLINGONCHER (Neisser's Clinic) (*Arch. of Derm. and Syph.*, Vol. 60, 1902, p. 100).

The clinical fact that, after tuberculin injections, zones of reaction appeared either in the place of localization of the tubercular process or far from its seat, was accepted as an expression of a non-specific inflammation in a specifically affected zone. The microscopical examinations of the writer show this to be an erroneous opinion and furthermore give a histological explanation of the clinical reaction. In all the places of reaction, both near the affected portion of skin and far from it he found microscopically a typical tubercular process, while clinically and microscopically no changes could be seen before the injection of tuberculin. This fact can be advantageously utilized in treatment of lupus, by determining, before medical interference with the lesions, the extent of the affected area.

1. **Inflammation Produced by the Vines of Primula Obconica.** —W. WECHSELMANN. (*Monat. f. pr. Derm.*, Vol. 35, 1902, p. 1.)

2. Primula Obconica as a Cause of Disease.—DREYER (*Munch. Med. Wochenschrift*, 1902, p. 574.)

This plant introduced in 1883 from China is the cause of inflammatory affection of the skin and mucous membranes. The skin affection is characterized by severe itching combined with a painful sensation of burning lasting for a longer or shorter period. The affected skin is red, swollen, covered either with wheals, or papulas, but oftener with large serous and sometimes with bloody blebs. Usually the hands, fingers, the interdorsal folds, dorsal aspects of hands, forearms, face, especially the eyelids, cheeks, chin and ears are affected—locations with which the secretion of the plant came in direct contact or to which it is transferred by the hands. As the plant is usually not suspected to be the cause of the affection of the skin, the patients do not avoid the contact and the disease takes a chronic course. The action of the virus is not simultaneous with the contact of the plant. Sometimes weeks may pass before the effect will be seen, as the patient hardly remembers had he come in contact with it. The virus does not act upon an uninjured epidermis, only when it passes into the deeper layers of the skin, when slight resorption takes place. The virus is not soluble in water, but it does dissolve in the secretions of the skin, especially in fats. Owing to this fact the therapy consists in the use of alcohol, applied locally to the affected parts. Zinc pastes and powders are also of use.

The recurrence of the disease in cases where contact with the plant cannot be proven, may be due to the fact that the virus has been left in the garments of the patient during his first attack.

1. A Note on the Occurrence of Bullae in Lichen Planus.—ARTHUR WHITFIELD (*The Brit. Jour. of Derm.*, Vol. XIV., 1902, p. 161.)

2. A Contribution to the Knowledge of the First Stage of Lichen Ruber Planus.—FELIX PINKUS (*Arch. f. Derm. and Syph.*, 60, 1902, p. 163).

3. A Case of Lichen Ruber Moniliformis Following the Subcutaneous Veins.—A. GUNSETT (Prof. Wolff's Clinic in Strassburg) (*Arch. f. Derm. and Syph.*, 60, 1902, p. 179.)

4. Lichen Planus of the Palm and Sole.—W. DUBRENILH and E. LE STRAT (*Ann. de Derm. et de Syph.*, III., 1902, p. 209.)

The occurrence of bullæ in lichen planus is rare. Whitfield gives the history of a patient with this rare complication. A typical lichen eruption covered the body, but both legs, especially the right one and right foot, were occupied with bullæ, which corresponded exactly with the papules. Histological examination showed that the bullæ were caused by a separation of the entire epidermis from the papillæ. The epithelium forming the sides and roof of the bulla was distorted. Below the bullæ the papillæ were flattened out and there was an infiltration of the superficial part of the corium with various kinds of cells. In analysing the literature which has grown up about this complication, the writer comes to the conclusion that arsenic taken internally cannot be regarded as a cause of the bullæ, as cases of lichen are reported with bullæ where arsenic was not administered; that there is no definite relation of the blebs to the lesions, that there is no consistent alteration of the blood, nor are the cellular contents of the bullæ of a definite kind; and that the seat of the bulla may be deep or only the horny layer alone involved. Pinkus (2) in

studying the histological development of the primary lesion of lichen planus concludes that the most characteristic points in the beginning of the formation of the papule are the conglomeration of lymphocytes deeper in the upper layers of the cutis and the migration of the polynuclear cells through the epithelial layers. The lymphoid celled infiltration plays an important rôle in the formation of bullæ in lichen planus, raising the epithelial layer from the cutis, destroying the rete. But in some cases the bulla is formed in the upper layers of the epithelium leaving intact the cylindrical layer.

Gunsett (3) took advantage of a case of lichen moniliformis which he had the opportunity of studying to determine the histological character of the lesions and give an explanation of their peculiar disposition. Histologically, the lesions showed a hyperplasia of the cells of the malpighian layer, hyperkeratosis with the formation of horny pearls and horny tags, a regressive metamorphosis of the cells of the malphighian layer with the formation of colloidal shells. In the cutis, a small cell infiltration of the papillary and subpapillary layers reaches into the lowest strata of malphighian layer, separated below by a sharp line, the infiltration extending alongside the veins, the papillæ being broken and broad, accompanied with a venous hyperemia. The distribution of the lichen was in the direction of the veins, although no pathological changes have been found either around or in the walls of the veins, except an enlargement of their lumen. The writer is inclined to ascribe to this enlargement an important rôle in the distribution of the lichen papules, basing his belief upon the experiment of Recklinghausen who injected zinc chlorid into the vein of a cadaver and obtained the same configuration upon the skin as presented by the lichen moniliformis.

Dubreuilh and Le Strat (4) give clinical history of three cases of lichen of the palms and soles. They picture the clinical symptoms of the disease upon the foregoing locations and enumerate the diagnostic points for differentiation from arsenical, eczematous, psoriatic and syphilitic kerotoses.

1. **Sarcoma Cutis Idiopaticum Pigmentosum Kaposi.**—V. M. KUDISH (*Russian Journ. Skin and Ven. Dis.*, Vol. III., 1902, p. 171.)

2. **Contributions to the Pathology of Kaposi's "Granulomata."**—J. SELLEI (*Monat. f. Prak. Derm.*, Vol. 34, 1902, p. 497.)

3. **A Case of Primary Sarcomatosis of the Skin.**—G. PINI (Prof. Majocchi's Clinic) (*Arch. f. Derm. & Syph.*, 61, 1902, p. 103).

Sellei (2) considers the importance of hemorrhages in the course of the development of the granulomata. To their occurrence is probably due the clinical fact that some of the growths are absorbed. The opinion of Kaposi that the involvement of the lymphatic glands in this type of granuloma is not characteristic of the disease, is questioned by the writer. In his investigations he found that the lymphatic glands take part in the process exhibiting histologically a productive connective tissue inflammation and the presence of pigment; as to the question whether the pigment was formed in the lymphatic gland itself or was only deposited there from other parts of the body, the writer is inclined to regard it as a deposit coming from the hemorrhages which take place in the skin tumors. He did not find any characteristic spindle-like cells in the glands.

Pini (3) gives a history of a patient who succumbed to a growth which in all probability started from a pre-existent nævus of the skin. The autopsy revealed

amyloid degeneration of the heart, kidneys, spleen, fatty degeneration of the liver, sarcomatosis of the lungs and skin. Animal inoculation as well as culture gave negative results. The histological examination of the skin tumor as well as of the tissues involved in the metastatic process showed a spindle cell sarcoma.

Kudish (1) reports a case of sarcoma cutis pigmentosum.

GENITO-URINARY DISEASES.

Some Points Relating to Renal Calculus, by SIR WILLIAM BENNETT, K.C.V.O., F.R.C.S. (*Philadelphia Medical Journal*, Feb. 22, 1902, page 365).

Three cases are described, which are intended to illustrate the uncertainty of symptoms in cases of stone in the kidney. In the first case the signs of stone were quite clear, yet there was a counter-condition in the shape of a urethral stricture, which might have been sufficient to account for the symptoms also. The presence of stone in the kidney was a mere coincidence, and had nothing to do with the stricture. The kidney was incised, and the stone extracted whole. There was considerable foul pus about the stone. Since the removal of the calculus, the amount of pus in the urine has decreased considerably, and the patient is much improved.

Case II was that of a man who complained of pain in the left loin accompanied with vomiting on two occasions. The usual symptoms of renal calculus were absent. Deep pressure elicited no tenderness, though the patient felt "as if there were something there." The kidney was incised, and a kidney-shaped stone was found in it. Recovery followed.

Case III was that of a young unmarried woman, with typical symptoms of renal calculus, of a severe character, except that no blood had ever been passed. Examination showed no stone in the bladder. One day after riding in an omnibus, she had an attack of hematuria, with great exaggeration of the pain. The kidney was cut down upon, but after a most searching examination, no signs of stone or pathological lesion could be found. The organ was sound to all appearances. Sir William is unable to state the cause of the patient's symptoms, though he is quite certain that the operation will cure her. It is quite likely that there may be a stone in the opposite kidney presenting "crossed symptoms." A. L. W.

The Roentgen Method in the Diagnosis of Renal and Ureteral Calculi, by CHARLES LESTER LEONARD, A.M., M.D. (*Medical News*, Feb. 15, 1902, page 305).

The Roentgen method is essentially a method of diagnosis, and as such should be used by professional men only, possessed of professional knowledge, special technic and clinical experience. In kidney affections, its value is unquestioned. In one case in which the diagnosis lay between ureteral calculus, chronic ovarian disease and appendicitis, the Roentgen examination excluded calculus, and operation revealed an inflamed ovary bound down by adhesions. In another case of difficult diagnosis, the skiagraph showed six phleboliths which the operation proved were in a varicocele of the broad ligament. In a case diagnosed as "nervous dyspepsia," the colic and gastric crises were found to have been caused by a calculus impacted in the ureter.

The skiagraph has shown that small calculi in the ureter give rise to "renal colic" more frequently than do calculi in the calyces or renal pelvis.

More than 60 per cent. of the calculi found by the author have been detected in some part of the ureter. In complete obstructive anuria, the recognition of the calculus as the obstruction, prevents operation upon the wrong kidney. In unilateral anuria, unless a calculus is passed and recognized, the subsidence of symptoms is to be taken as an indication of grave danger to the functional life and integrity of the kidney. Immediate operation is indicated if the calculus is found by the skiagraph, and if cystoscope shows the absence of urinary flow from the affected side.

In a case in which an operation was performed, and a fruitless search made for an encysted vesical calculus, the Roentgen examination showed four small calculi impacted in the lower portion of the ureter.

This method is the only means of differentiating between those cases that demand immediate operation, and those in which medical or expectant treatment is justifiable. In nine cases delay has been advised as a result of the examination, and the calculus has subsequently been passed. It is no longer necessary to perform an exploratory nephrotomy upon the healthy kidney before doing a nephrectomy, or to open a healthy kidney in the search for an obstructing calculus in the ureter lower down.

The accuracy of the negative diagnosis renders safe and rational the treatment of renal disease by purely medical measures, when the symptomatology does not point to some cause other than calculus.

In 206 cases of suspected renal calculus, referred to the author, calculi have been found in over 65 cases, and in over 60 per cent. they were in the ureter. In only three cases in which a negative diagnosis was rendered, was it found incorrect; in one case the error being due to faulty technic, in the other two the calculi weighed less than one grain each, and were overlooked and subsequently passed. The calculi that may be overlooked are so small that their final passage is quite certain. A. L. W.

Gonorrheal Infection of the Prostate, by JOHN VAN DER POEL, M.D. (*Medical Record,* Feb. 22, 1902, page 281).

Van Der Poel discusses the frequency with which the posterior urethra is attacked in acute urethritis. Admitting that this extension occurs in at least one-third of all cases, he is not prepared to agree with Finger and others that every case of gonorrheal infection of the posterior urethra extends to the prostate. He suggests that there is a likelihood of there having been a pre-existing state of simple glandular and follicular catarrh, in those cases taken to be gonorrheal extensions to the organ. He considers that a pre-existing congestion of the prostate favors extension of the gonorrheal process, even where it exists in a mild form.

The most common forms of prostatic inflammation are (1) the glandular catarrhal, (2) the follicular, a variety of the catarrhal, (3) the parenchymatous, simple or developing into an abscess. They are not sharply defined one from another, but are more or less intimately associated, one following the other. Gonorrheal infection of the prostate may develop gradually, and may be present in spite of the absence of subjective symptoms, and in spite of the clearness of the second portion of the urine. In most cases, the signs and symptoms are more or less marked.

On examination, the presence of many leucocytes in the massaged fluid is evidence of a prostatitis and seminal vesiculitis, even where the microscopical

examination is negative; other bacteria such as staphylococci or colon bacilli, are evidence of either a previous catarrhal inflammation, or of a so-called "secondary" infection in a subacute or chronic case, which condition may persist for years, and may be the cause of sterility.

Prophylaxis of prostatitis is synonymous with early and effective treatment of the anterior urethritis. If the extension backward can be prevented only in a certain number of cases, the frequency of prostatitis can be reduced. The author's treatment of acute urethitis giving the best results, consists of irrigations into the bladder of a ¼ to ½ per cent. solution of protargol, after anesthetizing the mucous membrane of the anterior urethra with 10 to 15 grams of a ½ or ¾ per cent. solution of cocaine in the acute cases. About 200 to 400 grams of the protargol solution are injected directly into the bladder by means of the large sterilizable urethral syringe, with a soft rubber or porcelain tip attached. This is repeated every 24 hours, with no intermediate hand injections by the patient himself. Should the prostate become attacked, massage must be added to the irrigations. A. L. W.

Multiple Arthritis in a Child Two Years Old Suffering from Gonorrheal Arthritis, by GEO. N. ACKER, M.D. (*Archives of Pediatrics*, February, 1902, page 97).

Acker reports the case of a child two years old, who presented a profuse discharge containing numerous gonococci, accompanied with severe pain on micturition. Seven days after this condition was first noticed, the right ankle became red, hot and swollen, with absolute limitation of motion. Inflammation of the right knee, left knee and ankle followed in rapid order as mentioned.

Under warm vaginal douches of boric solution, and local applications of 25 per cent. ichthyol ointment to the affected joints, the discharge and pain disappeared, and motion became normal again, five weeks after treatment was instituted. A. L. W.

A New and Improved Method of Closing Vesico-Vaginal Fistulæ, with Report of a Case, by A. LAPTHORN SMITH, M.D., M.R.C.S. (*Philadelphia Medical Journal*, February 15, 1902, page 327).

Smith reports a case in which he found a tear of the bladder, vagina and cervix uteri, extending from immediately back of the bladder sphincter on the patient's right, transversely downward and backward through the os on the patient's left, and measuring nearly two inches in length. The flow of urine over the raw surfaces had incrusted it with phosphates and somewhat thickened it. It looked as though the left blade of the forceps employed in the delivery had caught the bladder and cervix under the arch of the pubis and cut it there.

By adopting a new method of operation, which the writer has employed several times with success, there was little difficulty in closing the fistula, and the result was most satisfactory, not a drop of urine coming through after the operation.

After disinfection of the vagina, the latter was incised across, in front of the cervix, and the bladder pushed off the uterus in the same way as in the first step in vaginal hysterectomy. The laceration in the uterus which extended up to the internal os, was denuded and closed by Emmet's method, with chromicized catgut. The vagina was then separated from the bladder by the

finger, everywhere except where the two torn edges had become united at the fistula. With the finger between the vagina and the bladder, it was quite easy with a few cuts to separate them from one end of the fistula to the other. The edges of the long tear in the muscular wall of the bladder were brought together with an over and over fine catgut suture going back an eighth of an inch on each side, and taking care that mucous membrane of the bladder was not caught in the sutures. The slit in the vagina was closed with interrupted silkworm gut passed through the vagina, then through the muscular wall of the bladder, but half an inch through the right of the tear in the bladder, and then through the other side of the vagina, thus displacing the bladder half an inch to the patient's left, so that the line of suturing was no longer in the same place as the line of the tear was. This backed up the line of suture of the bladder with half an inch of solid vagina, instead of a line of sutures, and should any pressure be accidentally brought to bear upon the sutures in the bladder, it would have to overcome a valve instead of a hole, and the harder it pressed the tighter would the valve close. A *catheter à demeure* was left in the bladder for five days, after which the patient passed her water three or four times daily, and has had no trouble since.

The author points out that by his method may be avoided stitches in the mucous membrane, where they are liable to become the nuclei of troublesome calculi. Instead of depending on the union of a narrow edge about a thirty-second of an inch thick, a thick ridge is obtained fully an eighth of an inch thick in the bladder alone, to say nothing of the vagina in front of it.

A. L. W.

On the Diagnosis of Bilateral Cystic Kidney, by WILLIAM OSLER, M.D. (*American Medicine,* March 22, 1902, page 463).

Osler believes that the condition of bilateral cystic is seldom diagnosed during life. He reports two cases, in one of which the diagnosis was made easily from the characteristic combination of symptoms. These are (1) the presence of bilateral tumors in the flanks; (2) the cardiovascular changes of interstitial nephritis; (3) the condition of the urine, which is that of interstitial nephritis; (4) hematuria.

Polycystic kidney is rarely unilateral. Of 150 cases selected by Ritchie and Lejars, in all but three, both kidneys were involved. There is no difficulty in recognizing that the tumors are renal. In one of his cases, the tumors could be grasped bimanually and their situation and mobility left no doubt that they were enlarged kidneys. Other forms of bilateral renal tumor are extremely rare.

In one of the cases, the sclerosis of the arteries, the dislocation of the apex beat and the accentuation of the aortic second sound were very pronounced. The condition of the urine was characteristic—low specific gravity, slight trace of albumin, a few red blood corpuscles and scanty tube casts. This case also presented cholesterin crystals in the urine. The hematuria may be accompanied, as in this case, by pain.

Failure to make the diagnosis during life is due to the fact that the patients are seen with signs of cardiac insufficiency and dyspnea, and no attention is directed to the kidneys; or they are attacked with sudden coma or uremia.

As a rule, operation is contraindicated, and even in unilateral cases it is

stated that the remaining kidney may become cystic after operation. Henry Morris is quoted as having operated on three cases of cystic kidney, and in two of them the patients were alive and well several years after, adding that operation is indicated and justifiable if the opposite kidney has been found, either by inspection or palpation, unaffected. A. L. W.

Movable Kidney: With Possible Explanation of Failure in Some Cases to Relieve Symptoms by Nephrorrhaphy, by GEORGE H. MALLETT, M.D. (*American Medicine*, March 22, 1902, page 513).

The kidneys, though classed as fixed organs, really move up and down with respiration. They move through the arc of a circle in which the kidney vessels form the radius. The average range of motion varies from one-half inch to three inches, according to various authors. A palpable kidney is not necessarily a movable one. "Movable kidney" is the term used by the author to indicate a kidney that has a range of motion in excess of the normal, irrespective of the amount of mobility. The difference between movable kidney and floating kidney is but one of degree. Of all women who apply for treatment of various complaints, four or five per cent. have "movable kidneys." The causes of this displacement are divisible into two classes—those that weaken the kidney attachments, and those that lessen the intraabdominal pressure. The upper part of the ureter usually moves with the kidney and there is a great tendency for the ureter to become kinked at the junction of the movable with the fixed portion. This produces an intermittent hydronephrosis. The blood vessels may also be sharply flexed and interfere with the kidney blood supply.

The severity of the symptoms are in no way proportionate to the degree of mobility. Operation is indicated, however, when distinct symptoms are present which are unrelieved by mechanic or symptomatic treatment, and when secondary changes in the kidneys are present, due to mobility. In cases associated with general enteroptosis, an operation upon the kidney should be followed by a mechanic support of the abdominal wall.

The writer believes that when an operation is indicated and the symptoms persist after the operation, in most cases the kidney has been fixed in a malposition and the organ has rotated outward on its vertical axis in consequence. This condition has been observed after the usual operation, in which the external convex border was fastened to the bottom of the excision looking posteriorly, thus naturally rotating the internal concave border and the hilum more outward than normally, and facilitating the formation of a kink in the ureter and obstruction to the circulation, besides offering a better opportunity for downward pressure by the liver. The writer emphasizes the point that when performing nephrorrhaphy fixation of the kidney alone is not all that is required; care must be exercised that the circulation of the vessels and ureter is not interfered with. The possibilities of these occurrences are not so remote as have been supposed. A. L. W.

On the Association of Stone and Tumor of the Urinary Bladder, with Report of a Case, by EDWARD C. ROSENOW, M.D. (*American Journal of the Medical Sciences*, April, 1902, page 634).

Rosenow reports a case of carcinoma of the bladder complicated with a large round stone, weighing 150 grams, in a man 35 years old. The patient had complained of bladder symptoms since early childhood.

The writer presents several considerations which lead to the belief that in this case the stone preceded the tumor formation: (1) the much more frequent occurrence of uncomplicated cases of stone than of tumor; (2) the extreme rarity of uncomplicated carcinoma of the urinary bladder at this age (35); (3) the long continued urinary disturbances (30 years), and the mildness of the symptoms. It is unreasonable to believe that a carcinomatous growth should have existed for so long a period and have given rise to such slight disturbance. Carcinoma of the bladder is said to prove fatal within three years; (4) the large size and character of the stone.

Of 43 cases tabulated from the literature 37 occurred in males and 6 in females. The average age is 48 years, and they range from 6 to 79 years. In discussing the relation between calculus and neoplasm, the following arguments are presented which favor the view that tumor increases the liability to the formation of a calculus: (1) In 8 cases of the series there is no question but that the calculus was probably secondary to the tumor; (2) tumors, especially of the malignant type, are not infrequently found incrusted with phosphatic material; (3) villous growths are especially liable to cause calculi, because a poorly nourished projecting villus while yet attached or when torn off, may afford a nucleus, much the same as a foreign body around which the urinary salts are deposited.

As evidence that vesical calculus is a factor in the etiology of tumors of the bladder, the author mentions: (1) In over half of the cases it appears that the stone was primary in point of time. (2) Inflammation of the urinary bladder caused by irritation other than that produced by a calculus, has been found to cause an increased liability to new growths. If inflammation caused by chemical, bacterial, and parasitic causes enhances the likelihood of tumor growth in the bladder, the mechanic irritation from a calculus may have the same effect. (3) Tumor of the urinary bladder uncomplicated by stone occurs more frequently in the lower segment. In uncomplicated cases the posterior wall is affected more often than the anterior, the favorite site being at or near the orifices of the ureters, while in cases with calculus the anterior wall is the seat of the tumor in nearly twice as many instances as the posterior. (4) The large number of cases in which the calculus was primary in point of time and the fact that both calculus and tumor occur more frequently in the male sex and nearly at the same age, may be taken to indicate that the calculus was not without etiological influence in the development of the tumor. (5) Since in 90 to 95 per cent. of primary carcinoma of the gall bladder, biliary calculi are present, analogy would lead to expect that a similar relation would exist between stone and tumor in the urinary bladder.

The author therefore concludes that an etiological relationship probably exists between calculus and tumor, and that calculus seems to favor the development of tumor in a larger percentage of cases than tumor favors the development of stone. A. L. W.

Experimental Urogenital Tuberculosis.—(*Archiv für klin. Chirurgie*, 1901, Band lxiii.)

As the result of his experiments, Baumgarten states that he was unable to produce tuberculosis of the testicle by injecting tuberculous material through the urethra. By this means it was possible to produce tuberculosis of the deep

urethra, prostate and bladder, but never of the vas deferens, testicles, ureters, and kidneys. On the other hand, in every case in which the testicle was inoculated the disease extended to the vas deferens and prostate, but in no case did the other testicle or vas deferens become involved. The author states that he finds the explanation for his successes and failures in the generally known law that tubercle bacilli will never travel against the currents of fluids whether they be secretory or excretory; tuberculous infection may descend from the kidney or ascend from the testicle, but never vice versa. Clinically it has been noted that the disease may have the testicle as its primary focus.—(*American Journal of the Medical Sciences*, April, 1902, page 715.)

A. L. W.

The End Results of Castration for Tuberculosis of the Testicles. —*Archiv für klin. Chirurgie*, Band lxiii, Heft 4.)

Bruns reports 111 cases in which the operation was performed; in 78 cases a one-sided castration, in 33 cases both testes were removed. In all these cases the vas deferens was resected high up, but the seminal vesicles and prostate were not touched. In 38 per cent. of the author's cases, the disease was bilateral. In those in which unilateral castration was performed, 23 per cent. ultimately developed tuberculosis of the other testicle, which usually is apparent within two years after the castration. It is probable that in fully one-half of these cases both testicles were involved at the time of the operation. Of the unilateral operation cases, 12 per cent. died of urogenital tuberculosis, 15 per cent. of tuberculosis of the lungs or other organs; but it must be noted that fully one-third of these cases at the time of the operation had tuberculosis of either the lungs, bones, joints, or glands. After one-sided castration, 46 per cent. of the cases remained cured for between three and thirty-four years. After bilateral castration, 15 per cent. died of urogenital tuberculosis elsewhere, and 56 per cent. of the cases remained cured, the period of observation varying from three to thirty years. In not a single case was there any psychic disturbance as the result of the bilateral operation. Owing to the discouraging results of castration performed in the presence of tuberculous involvement elsewhere, operation is contraindicated in these cases. (*American Journal of the Medical Sciences*, April, 1902, page 713.) A. L. W.

Perineal Prostatectomy, by Parker Syms, M.D. (*Journal American Medical Association*, Nov. 2, 1901, page 1156).

Syms does not regard the Bottini operation as a sound surgical procedure, though he has had no personal experience with the method. It does not remove the hypertrophied prostate and can only partially relieve the obstruction in most cases. Secondly it leaves a slough to separate and come away through the urethra. Drainage must be through the burned wound, with liability to infection from the urine. Statistics published on the subject show that the operation is not free from danger and that it does not result in complete cure in the majority of cases. Prostatectomy is the preferable operation if the risks can be reduced so as to make it a feasibly safe procedure

The author, in performing this operation, has been very fortunate, having lost no patient, and having had a complete cure in all his cases save two. In one case a former suprapubic cystotomy had left a suprapubic abscess which had firmly fixed the prostate so that it could not be reached through the

perineum. In the other there has been some trouble from incontinence of urine. Suprapubic cystotomy in this class of cases is dangerous and should be avoided. In 1898 he suggested that a small incision be made through the abdominal wall just above the bladder fold, through which the operator could pass two fingers and with them, push the prostate, bladder and all, toward the perineum, enabling him with a finger of the other hand to reach and enucleate the prostate through a median perineal incision. The author has never tried to put this suggestion into practice, as he thinks he has been able to devise a much simpler means for accomplishing the same object. This is a bladder retractor (illustrated in the article) which enables one to pull the bladder and prostate down into the perineum so that the lobes can be reached and enucleated with the index finger. It consists of a soft rubber bulb cemented on to the end of a strong rubber tube, caliber 38, French scale. It is introduced into the bladder through an opening in the membranous urethra, the bulb then being distended till it has a diameter of two and a half to three inches, by forcing a definite quantity of water into it with a piston syringe. The tube is then clamped and when pulled upon, it draws the bladder down in the direction in which it is pulled.

In performing the operation, the rubber retractor is pulled down and then bent up over the perineum and held there by an assistant. When the index finger of the right hand, the operator perforates the capsule of the left lobe and begins its enucleation. The middle lobe, and then the right lobe are enucleated in the same manner. The clamp is removed, thus emptying the retractor, which is then withdrawn from the bladder, and a large perineal drainage tube is introduced through the urethra to drain the bladder.

By this method the hemorrhage is comparatively slight and there is very little shock. The author feels assured that in this way every hypertrophied prostate may be removed through a simple median perineal incision, and after this is done there is not a very formidable wound to deal with.

The author has operated on nine patients by this method, their ages ranging from 53 to 75. All had cystitis except one. The residual urine varied from 3 to 5 ounces. All the patients have lived, cure being complete save in the two exceptions above mentioned. A. L. W.

Prostatectomy Versus Prostatotomy in the Radical Treatment of Senile Hypertrophy of the Prostate, by RAMON GUITERAS, M.D. (*Journal American Medical Association,* Nov. 2, 1901, page 1156).

Guiteras describes at length the numerous operations devised for the relief of prostatic hypertrophy. All methods of relief have been discarded save catheter life, prostatectomy and prostatotomy. The catheter is used only when it is considered dangerous to perform one of the two operations mentioned, owing to the general condition of the patient; also prior to operation, with the object of treating the bladder and reducing prostatic edema or congestion.

The technic of the Bottini operation as modified by Freudenberg is described in detail. The results of this operation are most favorable; of 753 cases selected by Freudenberg in his last article, there were 622 successes, and 44 deaths, 12 of which were not positively due to the operation,—a total mortality of 5.8 per cent., and 17 failures.

Local or general anesthesia may be used. The writer prefers general anesthesia by nitrous oxid gas. Four per cent. solution of eucain or cocaine is

employed for local anesthesia. If cystoscopy is performed, the time required for it will usually be enough to allow the effect of the local anesthetic to pass off before the actual operation is begun, hence the writer advises either to use the cystoscope at an earlier date, or to again inject the local anesthetic after cystoscopy. It is advisable for this reason to omit cystoscopy just before the operation. In four cases under eucain anesthesia, the writer failed to pass the instrument owing to spasm of the vesical sphincter and nitrous oxid gas was substituted with successful result.

Perineal urethrotomy is sometimes advisable for drainage after the operation, in cases in which the gland is irregularly enlarged and the posterior urethra distorted by the hypertrophy.

Two methods of prostatectomy are employed by the author: (1) The vesico-rectal method, (2) the perineo-prevesical method, using counter-pressure in the space of Retzius.

The vesico-rectal method is the quickest method of removing a prostate known to the writer. With two figures of the left hand in the rectum, and the index finger of the right hand inserted into the bladder through a suprapubic opening, the prostate is palpated bimanually. A pair of curved, sharp-pointed scissors is passed into the bladder, the points are thrust into the most prominent part of the gland, and the bladder opened, thus tearing the tissues covering the gland. The finger tip is inserted into this opening and worked around between the gland and the capsule, making counter-pressure with the two fingers in the rectum. After enucleation the floor of the prostatic urethra is cut through with the scissors, to prevent formation of a pocket, the patient is then brought into the lithotomy position, and an external perineal urethrotomy is performed, inserting a perineal tube for drainage. Another tube is inserted into the bladder suprapubically and the bladder wall sewed tightly up to it. This tube is kept in place for one week, the perineal tube kept in place for three or four weeks.

The safest method, though not so rapid as the one just described, is the perineo-vesical method. A suprapubic incision is made into the prevesical space without going into the bladder. An external perineal urethrotomy is then done, with the patient in the lithotomy position. A pair of sharp-pointed scissors is passed into the perineal opening, the capsule of the prostate is cut through after which the tip of the right index finger is pushed in between the capsule and the gland, and enucleation is begun, while counter-pressure is made over the base of the prostate by the finger in the prevesical space.

The prostate having been completely removed, a perineal drainage tube is inserted into the bladder, and the skin and superficial perineal fascia sewn up to it. The suprapubic wound can then be closed, or a drain left in for a day or so.

Comparing published statistics of prostatotomy with those of prostatectomy, it appears that in the former there were 82.5 per cent. of cures, 5.8 per cent. of deaths, and 11.5 per cent. of failures; while in prostatectomy there were 72.3 per cent. of cures or improved, 16.4 per cent. of deaths, or 11.2 per cent. of failures. The mortality in prostatectomy seems to be three times as great as it is in prostatotomy. In those who survive, the failures are about as frequent as in prostatotomy, but the recoveries are better. It is difficult to say what constitues a cure in these cases.

The author considers it a first-class result if the patient can empty his

bladder of all the urine excepting perhaps 0.5 ounces of residual, especially if he is relieved of his symptoms. In general, it may be said that in those who do recover, the results from prostatectomy are much better and more permanent than in prostatotomy. In the former case, a repetition of the operation is never required, while prostatotomy must often be repeated.

Which operation is to be performed is to be determined by (1) the age of the patient, (2) the size of the prostate, (3) the condition of the kidneys and bladder. In general, middle-aged men with large prostates as felt through the rectum, having good kidneys and bladder, are cases for enucleation, while very old men with slightly damaged kidneys, and prostates that do not feel very large on rectal examination, yet causing considerable urethral impediment, are cases for prostatotomy. Old age *per se* is not a contraindication to prostatectomy. Very large prostates as felt through the rectum, are favorable for enucleation. Smaller prostates, in which there is a distinct impediment to the introduction of the instrument, together with considerable quantity of residual urine, are best for prostatotomy. In cases in which the gland seems very large per rectum, and in which there is a urethral impediment at seven inches or more, and the urethra is lengthened, hypertrophy of the lateral lobes probably exists, but if the gland is small by rectum and a similar condition exists as to urethra, the middle lobe is probably principally involved.

Diseased kidneys, whether medically or surgically involved, are always contraindications to surgical interference on the prostrate, as post renal congestion followed by uremia and death, may take place. If operation is demanded, in these cases, prostatotomy is the operation of choice, the danger being much less.

A. L. W.

Nephrectomy—A Clinical Study of Four Cases, by L. J. LADINSKI, M.D. (*Medical Record,* Feb. 8, 1902, page 212).

In the examination of the kidneys for disease, ureteral catheterization and cystoscopy with the Nitze instrument or its modifications, are the most important means at our command. When there is danger of possible infection from the bladder up into the ureters, the Harris segregator has been found very satisfactory, especially in the female. The X-rays have been used in a number of cases of renal calculus, but this method is not absolutely reliable, as a rule.

Cryoscopy, or the freezing test, is a test of the kidney function, not of its structure. If part of the kidney be destroyed as a result of some surgical disease, cryoscopy will determine if the remaining portion be functionating normally or not. The functionating capacity is also determined by the methylene blue test and the florrizin test.

The changes in the urine in various surgical conditions of the kidney are fully described in detail. The principal symptoms are : (1) Pain, (2) hematuria and pyuria, (3) tumor, (4) frequent and painful urination, (5) polyuria or anuria, (6) febrile condition.

The differential points in reference to these symptoms are also mentioned in detail.

The cases reported are 1, calculous pyelonephritis, female, 18 years old. In this case the calculus had remained in the kidney pelvis about five years, producing interference with the outflow of the urine by its action as a ball valve, and causing enormous distension, inflammation and hypertrophy of the

kidney pelvis, and degeneration of the kidney proper. Once the diagnosis of calculus is made early operation is indicated.

Case II.—Tuberculosis of kidney; female, aged 33. The kidney, when removed, showed the presence of many cysts of various sizes, the largest being that of a hazel nut, situated mainly near the cortex, and some of which were filled with cheesy purulent material. These deposits were found to be tubercular under the microscope. The writer believes that the process in this case was an ascending one, judging from the fact that the patient had a protracted vaginitis, urethritis, and cystitis long before there were any renal symptoms. During many months previous to and after the operation, tubercle bacilli were found but once in the urine, though frequent and careful examinations were made.

Case III.—Adenoma of the kidney, or struma suprarenalis. Female, 55 years old. Hematuria was the first symptom, followed by loss of weight and strength. Diagnosis of stone in the kidney was made by a physician at that time.

On operation, the lower pole of the kidney was occupied by a large tumor, which extended toward the pelvis. The growth was soft, vascular, and friable, and bled profusely. The kidney proper was removed first, leaving the tumor in situ, as it was impossible to extract both at once. The tumor was then found to be intimately adherent to the descending colon, pushing the latter forward and toward the median line. By blunt dissection, the tumor was removed. Since the operation the patient has gained 30 pounds, and is better and stronger than she has been in years.

Case IV.—Acute suppuration of the kidney. Female, aged 19. The interesting points in this case were (*a*) the rapid extension of the infection from the vagina upward to the kidney; (*b*) the differential diagnosis between acute suppuration of the kidney and puerperal septicemia; (*c*) the immediate and remarkable improvement following incision into the kidney (the organ was removed in a secondary operation); (*d*) the comparatively little constitutional disturbance after abscesses had developed in the kidney.

A. L. W.

Cases Illustrating Ureteral Surgery, by HENRY C. COE, M.D. (*American Journal of the Medical Sciences*, January, 1902, page 1).

Coe reports three interesting cases in which the ureters were severed accidentally in operations involving the uterus. In each case the severed ends were brought together as rapidly as the exigencies would permit, with wholly satisfactory results. The writer declares that it is sometimes impossible, especially in cases complicated with intraligamentary tumors to identify the displaced ureters before they are injured, and, therefore, every suspicious cord, adhesion, or supposed blood vessel should be carefully inspected before it is clamped or ligated, and again after it has been divided. When it is established by the escape of urine, that a ureter has been divided, the injury must be repaired at once, unless the desperate condition of the patient makes this impossible. No fixed rules, as to the method to be adopted, can be formulated. Each must be studied separately.

A. L. W.

Impacted Calculus in the Urethra in Children, by JOHN H. JOPSON, M.D. (*American Journal of the Medical Sciences*, January, 1902, page 10).

Two cases are reported. The first, in a male child, three years old, was accompanied by urethral rupture and urinary extravasation, which was made

evidently by a painful and general enlargement of the scrotum and perineum, involving also the abdominal wall as high as the umbilicus, and laterally and somewhat below Poupart's ligament on either side. In one hour the edema was seen to extend downward on the thighs in a line parallel to Poupart's ligament.

Under ether, the prepuce was split up and a sound passed into the urethra. About two inches from the meatus a calculus was encountered. This was cut down upon and extracted. Incisions were made in the scrotum, and in both groins, to evacuate the extravasated urine, and an English catheter was tied in the bladder through the perineum, and the wounds dressed.

Until the third day the patient did well. On the morning of that day vomiting set in, the temperature rose to 106° F., falling again after sponging to 99° F. by the following morning, when a bright red rash developed on the body and limbs. A probably diagnosis of scarlet fever was made. The local condition improved, but the child became weaker, delirious and restless, and died about two weeks after the operation.

The nature of the fatal complication remains a matter of doubt. While it resembled scarlet fever, it might have been a septic condition resulting from urinary absorption. Powdered iodoform having been sprinkled over the wound at the time of operation must also be thought of. There were no other cases of scarlet fever at the time in the hospital.

Case II.—Male, three and a half years old; symptoms, pain and retention. A calculus was found in the bulbous urethra, and removed by a median urethrotomy, it being impossible to remove it per urethram. The child made a quick recovery. No symptoms of any kind were noticed in this case before the stone became engaged in the urethra. A. L. W.

The Technics of Nephropexy, as an Operation per se, and as Modified by Combination with Lumbar Appendicectomy and Lumbar Exploration of the Bile Passages.—By GEORGE M. EDEBOHLS, M.D. (*Annals of Surgery*, Feb., 1902, p. 137).

Edebohls describes at great length the modifications of the technics of nephropexy that have been called for in his practice during the past three years, owing to the increasing knowledge concerning the relations between movable right kidney, appendicitis, and diseased conditions of the gall-bladder and bile ducts.

The relations between movable right kidney and appendicitis have demonstrated the necessity of removing the appendix in many patients who require operative fixation of the kidney. Removal of the appendix and anchoring the loose kidney are performed through one and the same lumbar incision, at one sitting. The peritoneum is opened on the outer side of the ascending colon. The appendix is found by following the longitudinal muscular bundles or bands of the colon downward to the cecum where they join at the foot of the vermiform process. The latter is delivered into the wound and either inverted entire into the caput coli, after tying off the mesoappendix, or else amputated, his own choice being inversion of the stump without ligation. The author has failed, for various reasons, in four out of fifty-six cases, in which he attempted lumbar appendicectomy. Of the 52 appendicectomies, the appendix was removed by inversion in 46 cases, and by excision in 6 cases. Only when appendicectomy is performed as a concomitant to right nephropexy, is the lumbar route indicated.

The writer believes, with others, that there exists an intimate association

between movable right kidney on the one hand, and cholecystitis, cholelithiasis, and their sequelæ on the other. In four successive nephropexies performed by the writer, lumbar exploration demonstrated the presence of gall-stones in two of the patients, and of chronic cholecystitis and pericholecystitis in the other two. Many hold the movable right kidney responsible for the disturbances in the biliary tract. His experience in this direction, embracing thirty-odd cases, demonstrates that direct examination of the gall-bladder may be made with satisfaction through a right lumbar nephropexy incision.

The author very frequently practises exploration through the lumbar incision on the occasion of a combined right nephropexy and lumbar appendicectomy. It is only necessary to enlarge the peritoneal opening required for the appendicectomy sufficiently to admit of free access to the gall-bladder, bile ducts, liver, duodenum, pancreas, pylorus, etc. He finds it unnecessary and uncalled for to go as far as Ferguson, who advocates preceding lumbar nephropexy by an anterior abdominal incision for the purpose of exploring the gall-bladder, the appendix, and the other kidney.

The history of nephropexy is fully gone into, credit being given to Hahn, as the father of the operation. In this country the operation was first performed by Weir, in November, 1882.

The operation must not be considered, as by some, as a minor kidney operation. The problem presented in performing nephropexy is briefly how to establish a new permanent anchorage for a movable kidney without damage, or with the least possible damage, to the organ itself, to surrounding parts and to the patient. With few exceptions all operators prefer the lumbar incision, and extraperitoneal operation and fixation. The classical incision running along the outer margin of the erector spinæ from the twelfth rib to the crest of the ilium, is employed by the vast majority of operators. The incision should leave the sheath of the erector spinæ unopened, separating but not severing the fibers of the latissimus dorsi, and deeper down opening the sheath and laying bare the fibers of the quadratus lumborum along the entire extent of its outer margin. Incision or blunt penetration of the transversalis fascia along the direction of its fibers brings us to the fatty capsule of the kidney and completes the approach to the organ.

The difficulty or ease of any lumbar operation upon the kidney, nephropexy included, depends very materially upon the degree of obliquity of the last rib and upon the endowment of the patient by nature with long or short twelfth ribs. A long twelfth rib and increased obliquity of the ribs generally coexist, and go hand in hand in rendering difficult approach to the kidney from behind. The author has been able in all his nephropexies and other operations upon the kidneys to overcome the difficulties connected with great proximity of the twelfth rib and ilium or with a long and oblique twelfth rib, by nicking the outer margin of the quadratus lumborum, at or very near its insertion into the crest of the ilium, to a greater or less degree according to the demands of the situation.

The so-called "kidney pain," in the outer side of the thigh and in the heel, and the hyperesthesia along the course of the iliohypogastric nerve, which so often follow this incision, are attributed to injury or section of the iliohypogastric or ilio-inguinal nerves, or both. This nerve damage may be avoided by drawing the nerve to one side.

Fixing the kidney in place is effected by means of sutures by most surgeons. The idea of deriving any aid whatsoever from the fatty capsule in supporting a

roaming kidney is fallacious, and its retention to any considerable amount facilitates the reacquisition of mobility by the kidney we have anchored. For the past three or four years the writer has made it a practice to remove the fatty capsule in its entirety in performing nephropexy, and others, probably influenced by the same considerations, have adopted the same practice.

As to whether there is a regeneration of kidney substance after injury or destruction by the passage of sutures through the parenchyma, the elaborate experiments recently recorded by Max Wolff seem to be the most convincing in this direction. Wolff finds that a new formation, a true hyperplasia, of uriniferous tubules and glomeruli never take place. The tubules and glomeruli in the remaining parts of the kidney simply undergo a compensatory hypertrophy. The epithelial cells of pre-existing tubules also undergo hypertrophy together with a very moderate hyperplasia. For the present it is deemed wise to base practical action upon these conclusions, although clinical evidence of the harmfulness of kidney sutures in man has as yet not been forthcoming.

Various operators have warned against fracturing the very friable kidney tissue by careless handling or undue traction upon sutures passed through the kidney substance. It has happened to the writer on three or four occasions to thus fracture a kidney with one of the sutures passed through its tissue. In one instance in the writer's practice, the transit of the needle itself through the kidney suddenly fractured the organ from the needle tract to the cortex; and it is quite possible that this accident was responsible for the three cases of urinary fistula following nephropexy that have been recorded. Taking into consideration the subjects of repair of the kidney after injury, fracture of the kidney by sutures, and urinary fistula following nephropexy, the writer abandoned parenchyma sutures as soon as he saw his way clear to a reliable capsule proper fixation method with denudation, but without suture, of the kidney parenchyma.

In considering the subject of anchorage, the writer believes that broad denudation of the kidney by stripping off a large area of capsule proper on the one hand, and laying bare the quadratus lumborum along its whole length on the other, will give the best tissues and largest surfaces available for firm and broad union. He anchors it squarely in the loin anterior to the quadratus lumborum muscle, and so situated that the middle part of the kidney fills the lumbar space, the upper pole projecting as far upward beneath the rib as the lower pole reaches downward below the level of the crest of the ilium.

The importance of maintaining the normal relations of the long axis of the kidney to the long axis of the body in performing nephropexy goes without saying. Unnatural anchorage and position of the kidney must certainly distort and stretch, to a greater or less extent, the renal vessels and the ureter, and expose the kidney itself to insults and traumatisms against which it is normally protected by the intervention between the organ and the external world of the osseous structures and the strong, thick muscles of the back. It has been shown that even ordinary palpation of the kidney for purposes of examination is generally followed by transient albuminuria and the appearance of blood and casts in the urine. How must a kidney suffer which, from its situation within the muscles of the back, is exposed to almost endless greater or lesser traumatisms?

The method, advocated by Myles, of nephropexy without sutures or tamponade is described. The perirenal fat is all removed; the capsule proper is split along its whole length; the glistening tendons of the quadratus and psoas muscles are laid bare; and the raw kidney is allowed to rest against this fibrous surface.

The comparative frequency with which different operators perform bilateral nephropexy varies greatly even in recent times. Bilateral nephropexy is especially indicated in patients in whom mobility of both kidneys is complicated with nephritis. Of seventeen such cases upon which the writer has performed nephropexy, the nephritis was confined to the left kidney in four, and to the right in four, while in nine it was bilateral. Bilateral nephropexy was performed upon thirteen of this group of seventeen patients.

The increasing frequency of bilateral nephropexy in the practice of the writer is shown by the fact that on his first fifty patients he performed bilateral nephropexy 10 times; on the second fifty, 15 times; on the third fifty, 28 times; and on the last thirty-six, 21 times.

The writer has performed in all 261 nephropexies upon 186 patients, of whom but 3 were males. In 108 cases the right kidney alone was anchored,in 3 cases the left kidney alone was anchored, in 1 case the right kidney was anchored twice, in 68 cases both kidneys were anchored at one sitting, in 6 cases both kidneys were anchored at two sittings. Total, 186 patients, 193 operations, 261 nephropexies. Of the 186 patients only two had a well-marked acute nephritis as a result of the operation. The affection ran a course of six weeks in one case and of two months in the other, and then permanently disappeared.

The writer finds on record nine cases of lumbar hernia following the operation of nephropexy. In five cases there was hernia of the kidney itself; in one the colon and intestines formed the contents of the hernial sac; and in three the protruding viscus or viscera are not mentioned. It is probable that the technics employed in performing nephropexy had something to do with the production of the hernia in the majority, if not in all, of the above cases. It is difficult to understand how a hernia can follow the lumbar incision carried from rib to ilium along the outer border of the erector spinæ, unless the incision be extended forward at either end, or unless the kidney be embedded in the muscles as part of the technique.

The author's present method of operating is described in detail, as are also the various steps by which his changes in technic have been brought about.

The mortality of the operation, judged by 846 operations, reported by 16 operators, is 1.65 per cent. Some of the deaths may be ascribed to causes other than the operation itself.

To determine whether a kidney has become detached after operation, the author depends on the extent to which the organ can be pushed upward toward the diaphragm. Unless he can crowd a kidney upward so as to make it disappear beneath the ribs, he regards it as anchored sufficiently well for all practical purposes. Judged by this test, not a single one of the kidneys anchored by the writer, has become detached. A. L. W.

Total Extirpation of the Prostate for Radical Cure of Enlargement of that Organ. —By P. J. FREYER, M.A., M.D., M. Ch. (*British Medical Journal*, Feb. 1, 1902).

Freyer describes four cases in which he performed this operation, the patients ranging in age from 65 to 76 years, and the prostates removed weighing from 3 to $10\frac{1}{4}$ ounces. Misconceptions of the true anatomy of the prostate, cause this method of enucleation of the organ and leaving the urethra intact, to seem absurd. He believes that the organ maintains through life its dual character, consisting in fact, of two distinct and separated, encapsulated glan-

dular bodies, or prostates, lying closely approximated to each other, and adherent above and below the urethral canal. In declining life when the gland becomes adenomatous, the adhesions, or "joining portions" give way, thus facilitating the removal of the gland in its capsule, as a whole, or in two separate parts, the urethra being left behind intact.

In one of the cases described, the urethra was by accident torn across at its junction with the bladder. No untoward result followed, the patient making a perfect recovery. In this case the prostate came away entire, having the shape and size of a large pear; it had been drawn off the urethra, which was severed at the neck of the bladder, just as a bead is drawn off a string. Not only the mucous membrane of the urethra, but the muscular covering as well, had been left behind, like a sleeve covering the contained catheter. On examination of the organ, it was seen that the lateral lobes were simply agglutinated together along the upper and lower commissures, and that by a little force, the separately encapsulated lobes could be peeled off each other along the middle line, thus demonstrating that the author's description of the prostate as consisting of two encapsulated lobes applied face to face along the middle line, and adherent above and below the urethra, is correct.

"Atony of the bladder" so-called, he believes, does not exist, even in the most advanced cases of the disease. The bladder walls retain their expulsive powers even when catheterization has been carried on for years. The efforts of the bladder walls to empty the organ of urine, are thwarted by the obstruction caused by the enlarged prostate; and though in the early stages of the disease, a so-called middle lobe may impede the flow, he is convinced that in the later stages the lateral pressure exerted on the canal is th main cause of the obstruction. Examination of the prostates removed show that where a so-called middle lobe exists, it is found to be merely an outgrowth from one of the lateral lobes.

A. L. W.

Remarks on Ten Cases of Movable Kidney.—By J. SCOTT RIDDELL, C.M., M.B., M.A. (*British Medical Journal*, Feb. 1, 1902, page 255).

The author distinguishes between "floating kidney" and "movable kidney." The former is a congenital condition, the peritoneum being so arranged as to form a distinct mesonephron of such length as to allow the kidney considerable play. It is more common on the left side. "Movable kidney" is acquired, usually found on the right side, and eight to ten times more common in women than in men. If it be present in a man, it is usually on the left side.

The tunica adiposa of the kidney encloses the organ in its meshes, and is firmly attached to the peritoneum in front and the loin posteriorly, forming a real ligamentum suspensorium renis. Outward and inward movement are limited respectively by the renal vessels and the mesocolon. Intraabdominal pressure and the protection of the ribs tend to prevent displacement. Limited displacement may take place as the result of strain, trauma, external pressure, or drag. This is followed by congestion and enlargement of the organ, which in turn brings about a distension of the retaining fatty capsule. None of the theories advanced to account for the greater frequency on the right side, is satisfactory. It is equally difficult to explain the intimacy between movable kidney and menstruation.

The pains occurring in the acute attacks, are caused by the twisting of the

renal vessels, particularly the vein, by rotation of the kidney. Incarceration of the kidney was formerly incorrectly thought to be the cause.

Diagnosis is best made by palpation; percussion gives no help. For examination the patient is placed on the back with the legs drawn up and recti as far as possible relaxed. With one hand in Israel's line in front, and the other in the loin, one can usually displace a movable kidney. Franks' rule with regard to the normal and abnormal movement of the kidney is quoted.

Of the ten cases described, five were nephropexies, all of which resulted in cures; three were nephrectomies, performed for severe hematuria, extreme hydronephrosis and fibroma, respectively; results were satisfactory; in two cases palliative treatment has been resorted to for various reasons. A. L. W.

Methods of Incising, Searching and Suturing the Kidney.—By HOWARD A. KELLY, M.D. (An address, published in the *British Medical Journal*, Feb. 1. 1902, page 256).

The ureteral catheter is of value in conditions where stone is suspected in two important ways, 1, before operation, the kidney pelvis can be thoroughly washed out with boric solution or weak carbolic acid, thus washing away the pus and rendering the surfaces relatively clean; 2, after washing out the pelvis, the catheter should be left in situ, the kidney being then exposed by the lumbar incision. Before the kidney is incised, fluid is forced rapidly into the renal pelvis so as to distend the pelvis and cause the kidney to swell up, making prominent certain landmarks which serve as a guide for a correct incision into the organ. If the kidney is grasped in the full hand during the distention, the exact position of the calices can be detected, as the organ alternately swells and collapses as the fluid is forced in. Sacculations and thinnings of the cortex are easily seen in this manner. Where calculi are present the antero-posterior diameter is sometimes increased up to 1.5 cm.

The distention of the pelvis and calices serves to further separate the two vascular systems found in the kidney, as pointed out by Broedel, thus reducing the hemorrhage to a minimum. The best place to incise the kidney is down through the lateral portion of the posterior pyramids between the anterior and posterior vascular trees. The worst possible incision is one that follows the course of, or wounds largely the vascular column found in the cortical septa between the pyramids. The best incision leaves about ⅓ of the kidney anterior and ⅔ posterior to the incision. Where suturing is advisable, three sets of sutures may be used to advantage; 1, fine catgut sutures placed between the calices, including the fat and fibrous tissues without involving the mucous surfaces; by this means the pelvis is approximated. 2. The most valuable set, consisting of one or two series of mattress sutures introduced with a straight slightly blunted needle, extending through the entire substance of the kidney; these control the bleeding. 3. For perfect accuracy, a continuous catgut suture, through the capsule. A. L. W.

Clinical Observations in the Treatment of Severe "Stammering" Bladder and Urethra.—By E. HURRY FENWICK, F.R.C.S. (*British Medical Journal*, Feb. 1, 1902, page 261).

Fenwick urges that the term "stammering" of the bladder, be confined to those patients, male or female, in whom urination cannot be effected at will, although all the organs for the completion of the act are sound and anatomically

perfect. False stammering should be applied to those cases of prostatic inflammation, senile enlargement, atony of spinal origin, or of urethral stricture which suffer from so-called nervous stammering, but in whom there is a distinct change, a deviation from health which induces reflex irritation, setting up the incoordination in the muscles regulating the expulsive effort.

True urinary stammering begins in youth, at or about puberty. The impression that it is caused by failure of the sphincter of the bladder to relax while the detrussor contracts, is not correct. The true cause is often a tonic spasm of the compressor urethra, and the cure is a longitudinal section of that muscle. If a terminal eyed catheter be passed until its eye rests in the membranous urethra, and the patient is told to urinate, he does so without any difficulty. If the spasm were in the sphincter, no urine would flow through the catheter. Moreover, section of this muscle has restored the patient to free and healthy urination, if the bladder has not become atonied through neglect. Latterly, merely tenotomizing the compressor urethræ without opening the urethral tube, has produced a similar satisfactory result. A. L. W.

Partial Nephrectomy—By B. G. A. MOYNIHAN, M.S., F.R.C.S. (*British Medical Journal*, Feb. 1, 1902, page 263).

Three cases of partial nephrectomy are described. The first was a cyst of the lower pole of the kidney, which was removed, together with the small portion of the organ which bore the cyst. The kidney wound was sutured with six deeply buried sutures of catgut. There was no bleeding. Recovery was without incident. The second case was a solitary cyst in the connecting band of a horseshoe kidney. The cyst was removed, together with some of the kidney substance. This created two separate kidneys, each with a sutured wound at the lower pole. The patient fully recovered. The third case was a myxosarcoma of the lower pole of the right kidney, in which half of the organ was removed. Recovery also followed. A. L. W.

A Preliminary Note on the Sterilization of Catheters; A Bacteriologacil Study.—By C. B. NANCREDE, M.D., and W.H. HUTCHINS, M.D., (*Medical News*, Nov. 23, 1901, p. 806.)

This is not the report of a completed study, though it already emphasizes the important fact that all of us must have often employed unsterilized catheters, when believing that they were sterile.

Using a mechanically cleansed new catheter for each patient, would practically secure freedom from infection. But when the same catheter is used for more than one patient, as is so often the case, the danger of infection is still great, in spite of the perfunctory methods of sterilization usually employed in private practice.

Sixty-five experiments were made, details of which will be given later. The germs employed were pure cultures of colon bacillus, staphylococcus pyogenes aureus, and bacillus pyocaneus and streptococcus pyogenes. Known quantities of these germs were put in bouillon and grown in incubator at 37.5° C. for twenty-four hours. New catheters were then immersed in this infected bouillon for five minutes, drained, and aseptically dried. After being subjected to the sterilizing agents, pieces of these infected catheters, or whole catheters, were introduced into sterilized receptacles, containing culture media, and incubated for from twenty-four to forty-eight hours.

The authors' conclusions from these experiments are: 1. That an infected soft rubber catheter cannot be completely sterilized by boiling under four and one- half minutes. 2. Mechanical cleansing from all dried pus, coagulated blood or mucus, will render sterilization easier, and will demand a shorter time to be effective. 3. Elastic (English web) catheters and soft rubber catheters can be repeatedly boiled for five or more minutes without roughening of their surfaces or diminution of their elasticity and strength. 4. Chemical sterilization by immersion in a 1:2,000 mercuric chlorid solution for five minutes does not sterilize any variety of catheters *which has become infected*, at best only inhibiting the growth of the germs, for if the mercuric salt be precipitated by ammonium sulphide the germs will grow freely when implanted in culture media. 5. The results of experiments indicate that chemical sterilization should never be employed for catheters which are to be retained in the bladder for some time, unless subjected to a very prolonged action of the mercurial salt, lest the merely inhibited germs develop. 6. Should corrosive sublimate be employed for the sterilization of catheters, it must be in a concentrated solution and the catheter must remain in it for a much longer time than the usual period considered amply sufficient in the laboratory, no mere washing with any chemical solution being efficient for *an infected instrument*. 7. Formalin vapor will sterilize infected instruments in twenty-four hours; how much shorter time will be sufficient, has not yet been fully determined. 8. All methods of sterilization commonly employed should be continued for much longer periods than the minimum time required for destruction of germs in the laboratory. 9. English web catheters can apparently be more readily sterilized by heat than can soft rubber catheters, probably on account of their interior construction.

The authors point out that the germs used in these experiments were probably less resistant to sterilizing agents than are those of the same species actually contaminating catheters which have been employed for cases of cystitis, because of the well-known loss of virulence of germs long cultivated upon artificial media. In future experiments it is expected that this defect will be removed by the employment of germs taken from actual cases of cystitis, when the justice of the statement of Guys that to insure sterilization of an infected catheter it should be boiled thirty minutes, will doubtless be recognized. A. L. W.

Therapeutic Reports

HOW TO ASSIST YOUNG GIRLS TO WOMANHOOD.

By Edward C. Hill, M.D.,
Denver, Col.

The oxidizing life of the blood is in the iron it contains, with about one-twentieth as much manganese. The total iron of the adult body amounts to but 2.5 or 3.5 grams, chiefly in the form of hemoglobin. The normal daily content of iron in the food of an average diet, is, according to Stockman, from five to ten milligrams. When absorbed, as in health, this food-iron replaces the metal continually lost by disintegration of blood corpuscles and excretion. The round of iron in the body seems to be from the duodenum to the mesenteric glands, thence to the thoraic duct, the general blood current and the spleen, from where it passes to the liver to be synthetized into hemoglobin for the red cells, on the breaking down of which the dissociated iron is eliminated by way of the large intestine.

The use of iron in anemic and chlorotic conditions is, of course, a cardinal principle in therapeutics. In girls becoming women to supply a deficiency of erythrocytes or hemoglobin, one might infer at first thought that the best method would be to administer hemoglobin, that is, blood in some form. Chemistry proves, however, that when hemoglobin is taken into the stomach it is changed by the acid there to hematin (causing the coffee-ground color of small gastric hemorrhages), which, according to Cloetta, passes down the alimentary tract without being absorbed.

Most authorities conclude that inorganic compounds of iron in order to be absorbed must first be changed to albuminates by combining with food matters. All albuminous substances are hydrolyzed to peptons before they are capable of absorption. Hence it follows that a peptonate of iron is the preparation most likely to be readily and completely absorbed and assimilated. The best remedy of this composition, I think, is Gude's Pepto-Mangan, which I have used for the past ten years with great satisfaction, particularly in the hemic and nutritive disorders of female puberty.

This neutral solution contains three grains of iron and one grain of manganese in each tablespoonful. The latter ingredient is doubtless to be credited with a large part of the nearly specific effect of the remedy in functional menstrual derangements. The preparation is pleasant to the eye, agreeable to the palate and has the great advantage over inorganic iron compounds of not corroding the teeth, deranging digestion nor inducing constipation. According to the nature and severity of the case, the dose varies from a teaspoonful to a tablespoonful. It is well taken in milk or sherry just after meals.

The following brief clinical notes may serve to illustrate the facts above stated. The blood count in each instance was made with the Thoma-Zeiss hemacytometer; hemoglobin was calculated by the Hammerschlag specific gravity method. I need hardly remark that the blood findings at the altitude of Denver are normally higher than at points near sea level.

Case 1. Jose K., 15 years, thin, delicate and somewhat strumous, had menstruated irregularly and intermittently for 16 months; erythocytes 3,600,000, hemoglobin 58 per cent. She was taken out of school, put on a diet largely protein, given aloin, strychnin and belladonna pills for her bowels, and for her blood, Pepto-Mangan (Gude), a dessertspoonful four times daily after eating. Under this treatment she made an average weekly gain of 1¼ pounds in weight, about 150,000 red cells and 3½ per cent. hemoglobin, and was discharged cured in ten weeks.

Case 2. Alice R., 18 years, rather stout but pale, with greenish tinge; complained of palpitation and breathlessness on slight exertion; menstruation barely begun and scanty. She was made to take gradually increasing exercise on her bicycle, a cool bath every morning, less carbohydrates and more proteins in her diet, and Pepto-Mangan (Gude) in the dose above mentioned. She recovered from all her morbid symptoms

Case 3. Amelia B., 23 years old, an overworked servant girl, had suffered since the periods first began, nine years before, with marked dysmenorrhea, the flow being prolonged but rather scanty. The red blood cells numbered 3,800,000 per cu. m.m., with proportionate oligochromia. She was induced to rest at home and take six eggs daily, along with other nourishing food and Pepto-Mangan (Gude), a dessertspoonful four times daily an hour after food. She made a very rapid recovery, the red cells running up to 4,900,000 within two months and the menstrual periods becoming quite normal. By exercising proper care she has remained well for the past eight years.

Case 4. Olive M., 13 years, blonde, thin, active, sensitive, a hard student, just beginning to menstruate, the flow being scanty and accompanied with pain. The blood count was 63 per cent. of normal, the color index 57 per cent. Under treatment similar to that mentioned in the first case, she became round and rosy, menstruated freely and easily, took on 17 pounds in weight and raised the blood findings above the normal at sea level, all within eight months.

Case 5. Fannie R., 17 years, active, ambitious, intelligent, had such excruciating pain all through her menstrual periods for two years as to cause actual wasting. Physical examination revealed nothing abnormal except an undersized uterus. She was given Pepto-Mangan in tablespoonful doses three times a day, and was told to lie with the head lower than the hips. After three months' treatment the periods became quite painless, and have remained so for five years.

Case 6. Flora J., 16 years old, began to menstruate profusely a year before, since which time she has been always ailing; erythrocytes 3,100,000 hemoglobin 63 per cent. She was given cool baths and massage, a bitter tonic, laxatives and Gude's Pepto-Mangan in dessertspoonful doses. When discharged cured five months later, the blood count was 4,700,000, hemoglobin 95 per cent.

In conclusion the writer would like to emphasize the peculiar physiologic efficacy of Pepto-Mangan (Gude) in aiding young girls to a normal womanhood, when the crisis of puberty is complicated with any defect in blood-making and nutrition. Its action is prompt and pleasant, and the clinical benefits derived from its use are readily apparent to all concerned. In curable cases it is as nearly specific as any combination of drugs could be.—*Brooklyn Med. Journ.*

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INJECTIONS

of Cypridol are vastly superior to all soluble or insoluble mercurials used hypodermically.

They are non-irritating and free from all untoward after effects.

Dispensed only in graduated tubes.

6 tubes in a box.

CEREVISINE

succeeds admirably in the treatment of furuncles, urticaria, acne and boils which promptly subside and disappear under its influence.

PURE DESICCATED YEAST

CEREVISINE

IN

SKIN DISEASES

CEREVISINE

Is indicated in cases of psoriasis, herpes and eczema; its effects being associated with corresponding improvement in the general health.

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